N. C. Dental Society

THE BULLETIN

....of....

THE NORTH CAROLINA DENTAL SOCIETY

CONTAINING THE

PROCEEDINGS

OF THE

SIXTIETH ANNUAL MEETING

JUNE 18, 19, 20, 1934

WILMINGTON, N. C.

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1. Clyde E. Minges, elected 1932
2. Wilbert Jackson, elected 1933
3. J. Martin Fleming, elected 1934

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OF THE

NORTH CAROLINA DENTAL SOCIETY

SIXTIETH ANNUAL SESSION

Cape Fear Hotel, Wilmington, North Carolina,

Monday, Tuesday and Wednesday, June 18, 19, 20, 1934

FIRST DAY—MONDAY, JUNE 18, 1934

Morning Session

The meeting was called to order by Dr. E. A. Branch, of Raleigh, North Carolina, President, at 9:30 o'clock a.m.

President Branch:

I now declare the Sixtieth Annual Meeting of the North Carolina Dental Society open and ready for business.

We will have the invocation by Reverend A. T. Brantley, Pastor, Trinity Methodist Church, of Wilmington.

Dr. Allen T. Brantley:

Direct us, O Lord, in all our doings with Thy most gracious favor, and further our works by Thy divine presence, that in all things begun, continued and ended in Thee, we may glorify Thy name. We would individually and collectively crave for a fresh interpretation of Thy self in us and through us. Our prayer this morning is not that Thy love should be in us, but that we should be in Thy love. That Thy truth should not be in us, but that we should be in Thy truth. That in all things we pray that Thou should not be in us, but that we should be in Thee. Being therefore, in Thee, Almighty God, we shall manifest Thee in our lives, and being in Thee we shall become servants and ministers in Thy kingdom. Let the benediction

of Thy holy presence be and abide upon this group of men, servants of God and servants of humanity, as it gathers in our fair City. Let our faith in both God and man:

"Spring like the eagle,
Who soars to meet the sun
And cries exulting unto Thee
O Lord Thy will be done.

Thy will it strengthens weakness;
It bids the strong be just
No lip to fawn, no hand to beg
No brow to seek the dust.

Wherever man oppresses man
Beneath the liberal sun
O Lord be there, Thine arm made bare
Thy righteous will be done."—Amen.

President Branch:

Gentlemen, we will hear from the Honorable John J. Burney, city attorney for the City of Wilmington in an address of welcome. Mr. Burney.

Mr. John J. Burney:

Mr. President, members of the North Carolina Dental Society, distinguished guests, ladies and gentlemen: It is indeed a pleasure for me to be allotted the pleasant task of officially welcoming you to this great city.

You have probably been to many cities and they have told you perhaps how fortunate you were to meet in their fair city as your gathering place; but we do just the opposite with you in Wilmington—we want to tell you just how fortunate we are to have a crowd of men such as you to meet in our good city.

Wilmington is a quaint old-fashioned city; more than two hundred years old; one that has not grown by leaps and bounds in population; one that we cannot tell you that we have the greatest streets nor the most wonderful parks as any other city where you have been before; one that we cannot tell you that has the greatest mansions like the ones of the Persian princes; one that has not great public buildings and portals as great or greater than those at Athens and Rome; but Wilmington is a City of Americans, where the population is 99.7 per cent American, and where even now you will find real Southern hospitality and where they love to have men such as you come and to have you bring along your beautiful wives and daughters and mothers and spend the short time that you have in our wonderful city.

I could probably take several hours and tell you many, many things about Wilmington; of the great historical features; I could tell you—but probably most of you know—that the first arms resistance to the Crown of England back in the Revolutionary days was near this city; that in 1766 when they arrived with their arms and the governor triumphantly appointed a stamp-master and they actually established themselves at Brunswick, just below Wilmington; that Colonel Ashe and Colonel Waddell marched there with a militia from New Hanover County and defied them to sell the stamps here and that they came to this quaint old city and marched up and down the streets and there were great times in this old city that night, ante-dating, my friends, by eight years the Boston Tea Party.

So, you are now in the city where real American freedom was first started, and you are in a city that has been honored by a great number of great men. Five presidents of the United States have visited this city; the great Daniel Webster visited Governor Dudley here in 1647. And while they tell you of other places and about the glorious sunrises and glorious sunsets, down here we have not so much that way, but we do boast of the wonderful moonshine we have here. (Laughter.) And I mean by that not, my friends, what you are thinking about, but when night comes you can go down to the Inland Waterway and there you can get on a boat and take a little maid, along, and a little banjo or some other musical instrument; and with the breezes that come along old Wrightsville you can sail about in that moonshine and you can tell stories as sweet as have ever been told, and you can hear the birds singing down here as sweet a music as you have ever heard sung anywhere. And those who live here can tell you that this is a place where we go to sleep listening to the hum of the birds and wake up in the morning and bask in the fragrance of our gorgeous flowers.

I say, the people of Wilmington are proud to have you here; and we hope that you will have a most glorious time.

We have been through quite a little trouble in the last few years; we have seen youth lose hope and the old despair; but the clouds are drifting away, and America is still safe, and we are still going on and we are still the greatest nation there is today. And we hope that you will receive inspiration here and your rest will enable you to go back to your own homes to do more for humanity in the future than you have in the past.

We are always glad to have you and we hope you will do this again and that you will not wait until you have another convention. I have been requested to say that you should see your entertainment committee at least once every hour and your wife at least twice a day. (Applause.)

President Branch:

We will have the response to the address of welcome. Dr. Carl P. Norris, of Durham, North Carolina.

Dr. Carl P. Norris:

Mr. President, ladies and gentlemen: There was a bride who was attending church for the first time after she was married. She was seated on the opposite side of the church from where her husband was acting as usher. About the time that the minister was about two-thirds through the sermon she remembered that she had left the fire burning under the roast at home. So she wrote a note to her husband and handed it to an usher nearby; and he made a mistake and took the note up to the preacher. And the preacher paused in the middle of his sermon and read "Go home and turn off the gas." (Laughter.) I hope it will not be necessary for you to remind me, although I realize that a response should be very brief.

I feel rather in a dilemma this morning in trying to fittingly respond to such a splendid address as you have just heard. I am almost in the dilemma the golfer was in who started out to play golf for the first time. He had never seen a game of golf, so he went to a store and bought a bag of clubs, not knowing the names of the clubs nor how to use them. He went out on the golf course and he was given a caddie who had never seen a game of golf; and they started out together. The caddie laid his ball down and handed him a putter and he drove with all his might. The ball landed over in the rough and in a stump hole. The caddie handed him a brassy to get it out with, and each time he was handed a different club; until finally they got within about thirty yards of the green and the caddie handed him another club. He drove with all his might, the ball went straight up into the air and fell directly into the cup. Neither of them said a word but walked up to the cup and looked in. Then the man turned to the caddie and said: "What shall I do to get it out of that hole?" The caddie said, "I don't know what you will do, but you are in a hell of a fix." (Laughter.)

We are glad to welcome the North Carolina Dental Society to this seaport town that serves a State larger in area than that of New York or Pennsylvania and nearly as large as the whole of New England. We come from every nook and corner of this great old State and yet we are not unfamiliar with Wilmington and this vicinity. We, in our homes consume the freight and produce of the soil. It is stated that this section is the greatest vegetable-growing section in the United States. We certainly delight in your delicious strawberries. I am told that this is the greatest strawberry-raising district in the entire

world. Wilmington has a great deal to be proud of. You have here the head of one of the South's great trunkline railways. We are all familiar with the historic Cape Fear. You have excellent water transportation, with your growing exportation and importation. You have an abundance of raw material, making Wilmington one of our best cities. We like your streets, we enjoy your parks, we admire your beautiful old homes. We enjoy coming to your seaside resorts and bathing in the waters of the South Atlantic. We enjoy the cool invigorating ocean air, and we, too, like your people.

It is true that the people really make a city. I feel that today you have heard a genuine old Southern welcome. I like to think of that traditional Southern hospitality that has existed here throughout the years. I do not share the opinion of a great many people that this hospitality is disappearing, and I hope it never will.

We are glad to see you; we are glad to be in your city; and we appreciate these kind words of welcome. I thank you. (Applause.)

President Branch:

I will ask our Secretary to read some communications that he has on hand.

Secretary Pridgen:

Gentlemen, the following communications have been received:

Wilmington, June 18th, 1934.

To the Membership of the North Carolina Dental Society,
A Friendly and Cordial "Good Morning":

Supplementing and endorsing fully the friendly and official welcome extended to you by Hon. John J. Burney, attorney for the City of Wilmington, may we express to you every good wish, combined with the hope that you will call upon us for any personal service we may render while you are here for this visit, and for future anticipated visits which you may honor us with.

Our offices are located on North Third Street, directly in front of the Municipal Building. It will give us extreme pleasure to supply maps of the county, etc., and to offer any suggestions which may assist you in "seeing Wilmington." We trust especially that each and every delegate will take advantage of the opportunity while here to see the many and varied beautiful pictures afforded by the five-mile scenic drive around Greenfield Lake, in the southern section of the city. This drive may be approached via. either the south extension of Third or Fourth streets. We can assure you that the

entrancing views which you will see, will linger long in the memory of everyone.

With further expression of unbounded pleasure that your representative body is meeting in Wilmington—North Carolina's Developed Deep Water Port—we are,

Cordially and sincerely yours,
WILMINGTON CHAMBER OF COMMERCE,
LOUIS T. MOORE, *Executive Secretary.*

Greenville, N. C., June 18, 1934.

Dr. E. A. Branch,
Cape Fear Hotel, Wilmington, N. C.

Best wishes for a successful meeting. Wife's illness prevents me from attending.

B. McK. JOHNSON.

Asheville, N. C., June 18, 1934.

Dr. E. A. Branch, President N. C. Dental Society,
Cape Fear Hotel, Wilmington, N. C.

It is with deep regret that I am unable to be with you. Wishing you a most successful meeting and with kindest regards and best wishes to you all. Fraternally,

NAT.

St. Paul, Minn., June 18, 1934.

Dr. Wilbert Jackson, President N. C. Dental Association,
Cape Fear Hotel, Wilmington, N. C.

Best wishes for a successful meeting. Saint Paul committee hard at work to put on a real scientific meeting for visitors to the Seventy-Sixth Annual Session of the American Dental Association, August 6-10. We are waiting to welcome you.

IRWIN A. EPSTEIN, *Chairman Publicity Committee.*

Chicago, June 1, 1934.

Dr. Ernest A. Branch, President,
North Carolina State Dental Society,
State Board of Health,
Raleigh, North Carolina.

Dear President Branch:

Before leaving for the Pacific Coast to be in attendance at state meetings from Los Angeles on the south to Tacoma, Washington on the north, and then across the Sierra and Rockies to Denver, Colorado, for the Colorado State Meeting, I wish to convey to you and ask you to convey to the men of your State the greetings and best wishes of the officers of the American Dental Association.

I regret more than I can tell you the fact that I am unable to be present and participate in the deliberations of your annual meeting. However, I do wish for one and all a happy and profitable meeting.

I can assure you that conditions in general regarding our pro-

fessional conditions are reasonably satisfactory, and the fact that we have increased our membership over the same date last year nearly six thousand is most encouraging and indicates to me that the men of the profession are awakening to the advantages of belonging to organized dentistry. When the drive for membership is finally launched, I feel sure we will be stronger numerically than at any time in the history of our organization.

Wishing you an enjoyable program, and the heartiest of fellowship, I remain

Cordially yours,
A. C. Wherry, *President.*

Dr. J. P. Jones:

Ladies and gentlemen, we will now have the address by our President. Doctor Branch. (Applause.)

President Branch:

Ladies and gentlemen, I want to thank first the committees who have assisted in the work this past year in arranging this program. Especially do I want to thank Doctor Pridgen, who has had a great deal of the burden to bear and who has borne it in an admirable way.

PRESIDENTIAL ADDRESS

By Ernest A. Branch, D.D.S., *President*
North Carolina Dental Society

It is an honor to be elected president of any organization. I am grateful that you have expressed this confidence in me and honored me with the presidency of this organization this past year.

Presidential addresses are ofttimes made up of a series of recommendations. However, it is not my purpose to burden you with recommendations or advice of a dictatorial nature. Nevertheless, I do desire, during the few minutes allotted for this purpose, to counsel with you and study what we are pleased to call "Dentistry's Task."

As you know, I am and have been for a number of years, interested in public health. Public health's purpose is nothing more nor less than the teaching of prevention of disease. Although some of your leaders of today preached prevention of disease through a knowledge of mouth hygiene twenty and twenty-five years ago, they became discouraged because the majority of the profession of that day was not sufficiently far sighted to understand their preaching. There are men in this gathering, now life members of this organization, who made a lasting contribution to dentistry by their interest in and public utterance of the same things that we are preaching and practicing today. We could name perhaps a dozen who would come in that list. However, it is not necessary that we name them. We know

who they are, and once they had their eyes fixed on the goal, they never turned back.

North Carolina occupies a peculiar place in mouth health in its relation to Public Health history. It was the third state in the Union, we understand, to have a dental member on its State Board of Health. It was the first state to establish mouth health teaching in the public schools of the State, and it was the first and only state to pass a law providing for a dentist as a member of every county board of health. Regardless of what you may know about it, or think of it, the State's mouth health programs are attracting not only nation-wide, but world-wide attention. We are constantly receiving inquiries as to its plans and policies.

Dentistry today is considered a branch of medicine and it is also considered an integral part of every public health program—which is a program for the prevention of disease. There are two classes of disease with which public health must contend. First are *communicable* diseases. I am glad to say that these are on the decrease. In this classification come typhoid fever, malaria, diphtheria, measles, whooping cough, smallpox, etc. The reason for the decrease in these diseases is due to education along the lines of prevention. Public health activity has accomplished this. There is not a man within the sound of my voice who would be willing to turn back.

The other group of diseases we call *degenerative* diseases. This classification takes in diseases of the heart, kidneys, and lungs. Our records show that these diseases are increasing every day. The medical profession is agreed that ninety per cent of the degenerative diseases enter the body by way of the mouth and nose. This being true, then it stands without argument that if these diseases are to be decreased they must be decreased through prevention, and this prevention must be along the lines of education as to the relationship of an unclean mouth to systemic disease. This is the main plank in dentistry's platform, and is sufficient reason to place it in every public health program.

Educational Opportunities

In the schools of North Carolina we have enrolled between nine hundred and fifty thousand and one million children. We have four hundred thousand too young to go to school. We have eighty thousand new babies born every year. The difference in the number born each year and the four hundred thousand too young to go to school at the age of six, represents the enormous death rate of children under two years of age.

Another high death rate in this State, of which we are not proud, is the maternal death rate, or the deaths among women during or shortly after childbirth. Dentists have an unusual opportunity in helping to lower both these death rates. Many times a pregnant woman consults a dentist for the relief of pain from an aching tooth, but has never consulted a physician regarding her pregnancy. When you find this is the case, it is an opportune time to stress the importance of physical examinations, and to urge that she should by

all means consult a physician immediately, not only for her own sake, but for the sake of her child as well. There are many other reasons that may suggest themselves to you during the course of your conversation with the woman. If you fail to take advantage of this opportunity of being of health benefit to a patient, we believe you are failing to render the proper service and to live up to your unusual opportunity and privilege.

When the children in our schools are examined for physical defects, and the defects are classified, we find more children listed under the classification of "undernourishment" than any of the other defects. This condition should not exist in this great State of ours, where we grow everything the body needs. We should impress upon the individual parent, especially the mother, the importance of the right kind of food. We should discuss with her food values and proper health habits. The opportunity the dentist has to recognize undernourishment in the child makes him indispensable in a public health program, because undernorishment must be corrected through education along the lines of foods, food values, and proper health habits. The dentist is especially trained in this. In fact, the dentist is looked upon today as being an authority on foods and food values. His training is such that he has a decided advantage along these lines. Undernourishment, as indicated by the teeth of the child, reflects back before birth and this is easily recognizable by the dentist. Not only undernourishment before birth, but undernourishment at the present time is also recognized by the dentist, and to him the evidence he sees in lack of development of the teeth is just as conclusive as that of a chemical analysis of the blood would be. This is a tremendous advantage to him.

We trust at a not far distant date that the extra curricular activities in our schools will be restored, at least insofar as home economics are concerned, in order to better enable us to sow the seeds of mouth health in a fertile field. The value of health is being stressed today to the point that it is being taught in a more or less ecceptable fashion by several agencies, all the way from public health direction and insurance agencies to manufacturers of foods and cooking utensils. In the handwriting on the wall, and from all evidence that we can gather, this is being readily accepted by the public. The fact is that the public is anxious for it and is swallowing it down bait, hook, and sinker. We as a profession whose special duty (and responsibility, if you please) it is to guard the "Gateway to the Body," popularly called the mouth, are standing by. Are we going to sit idly and see this educational program taken away from the dental profession by members of the laity; see them steal our thunder; carry the flag, and occupy the promised land which is ours by birthright, training and inheritance? We are not going to allow any such thing as this to happen. I know we are not, because our experiences in the past bear proof that in days gone by we have been equal to every occasion. When opportunity opened the door, we were ready to enter, and the door has been thrown wide again recently by our Mouth Health Survey.

MOUTH HEALTH SURVEY.

Something never heard of in the annals of public health happened in North Carolina in February of this year. On two days practically every dental office of members of the North Carolina Dental Society was closed, and the dentists were in the public schools, giving their time as a contribution to mouth health improvement. This was done without any financial remuneration whatesoever. We now have the reports of this survey from all five of the districts. I wish we had time to go into each one of them in detail, but time will not permit. To show you just how closely one resembles the other, we are giving the following figures: In the First District, one hundred and fifty schools were inspected; in the Second, one hundred and thirty-five schools; in the Third, one hundred and thirty-two schools; in the Fourth, one hundred and thirty-three; and in the Fifth, one hundred and fifty-three. No district knew exactly what the other districts were doing. In these five districts, we found that two hundred and thirty-five thousand, three hundred and seventeen children were inspected; thirty-seven thousand, three hundred and nineteen children needed no dental treatment, or only sixteen and two-thirds per cent. One hundred and thirty thousand, three hundred and eighty-five children had never visited a dentist—approximately fifty per cent. We found that thirty-seven thousand and twenty-four permanent teeth needed extraction, and one hundred and seventy-four thousand, two hundred and forty-four permanent teeth needed filling. We also found eighteen thousand, three hundred and forty-four six-year molars missing. We found twenty-one thousand, one hundred and three children had diseased gums—approximately twelve and one-half per cent.

Now we could enumerate and go further into this, but there is no need to bore you with figures at this time, because the entire report will be made available to you a little later on. However, the significant thing in this report is the fact that fifty per cent of the children enrolled in the schools of North Carolina have never been in a dental office. Gentlemen, if you will consider what I have previously said in my presidential address, and if you will think on the fact that this vast number of children have never been in a dental office, then I believe you will agree with me that dentistry's task in North Carolina is one of MOUTH HEALTH EDUCATION. (Much applause.)

Dr. J. P. Jones:

I would like to appoint J. H. Wheeler, Paul Fitzgerald, and B. C. Taylor, to make a report on the President's Address.

President Branch:

Next we will have the report of the Necrology Committee. Doctor Betts.

Dr. J. S. Betts:

Mr. President, members of the North Carolina Dental Society, ladies and gentlemen: At this hour, in keeping with one of our beautiful customs, we assemble to commemorate the lives, character, and public services of those of our number who have passed into the Great Beyond since our last meeting. Charles Lee Alexander, Percy Bunn Cone, J. E. Wyche, Dr. Delia Dixon Carroll, an honorary member.

At this moment I am going to ask Reverend Doctor Barnhart, pastor of Grace Methodist Church in the City of Wilmington, to lead us in prayer. (All stand.)

Reverend Barnhart:

Our heavenly Father, we uncover our heads; we stand in Thy presence, in memory of those who have lived among us, who have wrought nobly their life's calling and have now slipped within the vale of sense. We thank Thee for the memory of their lives, for the high principles which they practiced in their profession, for the good which they have accomplished in the world and for the character which they developed, not only for this life but for the life which is to come. Wilt Thou bless us in relation to their memory and may we standing in the presence of this greatest delusion of all time which men call death, realize that there is a triumphant note even in their passing. May Thy spirit guide us in our deliberations at this moment, by our words and by our deeds may we honor their memory. Cherish their record in our midst; God rest their ashes; and keep our feet in the way Thou wouldst have us walk. In Thy holy name. Amen.

Doctor Betts:

In these times, when men and women serve the public in any capacity, they are often misunderstood, their motives maligned, and sometimes evil is attributed to their activities. Therefore, it is well for us to make a record of those who have passed from us, to note the good that they were able to accomplish. We are profoundly disturbed by the circumstances that bring us together, and a deep sense of solemnity overwhelms us at the unanswered roll call that was the roll call of the living. We heard no response in this chamber from them. Once they enjoined us in answering to their names.

I am going to recognize Dr. Ralph M. Jarrett, of Charlotte.

Dr. Ralph M. Jarrett:

CHARLES LEE ALEXANDER, D.D.S., F.A.C.D.

Dr. Alexander was born on a farm in Mecklenburg County, North Carolina, at Tuckaseegee Ford, about ten miles from Charlotte, on the 12th day of February, 1861. He was the eldest son and third child of a family of seven children, born to Amzi and Martha Wilson Alexander.

Dr. Alexander's early boyhood days were spent on the farm where he was born, but his father later moved with his family to Charlotte, the county seat, to practice dentistry. Convinced that he should follow his father's profession, he gave up his academic pursuits at the Carolina Military Institute and entered the Baltimore College of Dental Surgery in 1880. He continued his course of study in that school until the spring of 1882, when he graduated with high honors, and immediately on his return home associated himself with his father. Later his father moved to Lincolnton, N. C. Dr. Alexander then associated himself with Dr. Hoffman at Charlotte, for several years.

Dr. Alexander was not in the practice of dentistry very long before he realized the benefits to be derived from a broader acquaintance with the people of his native State. He arranged, therefore, to spend a week each fall and spring to practice at some of the educational centers of North Carolina. Accordingly he practiced at Chapel Hill, Trinity, Davidson College, Wake Forest, and Bingham School, and, in addition, he spent some time each summer practicing at Morehead City, which was then a famous resort.

This experience made for him many staunch friends and resulted in the addition of a number of influential people to his clientele, many of them remaining under his professional care throughout their lives.

Convinced of the value of a better knowledge of general medicines than was to be obtained in dental schools of those days, he went to Baltimore in 1887 and entered the college of Physicians and Surgeons and while there served his Alma Mater, the Baltimore College of Dental Surgery in the capacity of clinical demonstrator. On his return to his native State he soon forged to the front in his profession. His thorough training and his exceptional ability, to say nothing of the charm of his personality, all contributed to his success. It was his remarkable inventive genius, however, which more than anything else won for him a position as peer of the leading men in the profession of dentistry. His original inventions, his improvements of old methods and his contagious enthusiasm for progress have gone a long way toward revolutionizing modern dentistry.

Dr. Alexander's mind was an inventive one and has many patents to his credit, both in dentistry and outside. In 1889 he perfected the three-quarter saddle, and hood crown abutments giving these to the profession in 1896 before the Southern Dental Society in Atlanta, Ga.

He originated the gold inlay from which came the cast gold inlay. His art in bridge work was known throughout America and Europe.

Dr. Alexander's flattering success in private practice did not interfere with his love for his profession as a whole, or with his duty to his profession. He read papers and gave clinics at local, state, national, and international associations. He was always active in society work, having served continuously on state committees and as President. He has been a member of all international congresses, Vice-president of the Fourth International Congress, was corresponding secretary of Southern Dental Society, Vice-president of the American Dental Society and was chosen delegate to the Fifth International Dental Congress, held in Berlin, Germany, to represent the National Dental Association of America.

Dr. Alexander married Miss Sue Odom of Baltimore, Md., on December 20th, 1888. Three children were born as a result of this marriage. Charles Lee, Jr. (deceased), Odom, and Eleanor Wilson. Mrs. Alexander's death came February 11th, 1925.

Dr. Alexander was again married to Mrs. Thomas D. Tyson of Carthage, N. C.

Dr. Alexander was a most lovable person, ebullient with true Southern hospitality, was loyal to the last degree, and was an unyielding champion of the principles which were so instrumental to his success in life and in the life of his profession.

His coming, his lingering, and his going has left the world a better place in which to live, and made the road of his colleagues easier to travel.

Doctor Betts:

The chair will recognize Dr. Paul Jones.

Dr. Paul E. Jones:

MEMORIAL TO DR. PERCY BUNN CONE

By Dr. Paul E. Jones, Farmville, N. C.

Died in St. Elizabeth Hospital, Richmond, Va., following serious surgical operation, Percy Bunn Cone.

Dr. Cone was born in Wilson, North Carolina, August 21st, 1887. His father was Burtis Cone of Nash County, his mother was Octavia Bunn of Johnston County. The first twenty years of his life was spent in Spring Hope, N. C. His preliminary professional education was obtained at Oak Ridge School, after the completion of which he matriculated at the Medical College of Virginia, at Richmond, in September, 1907. Graduating in dentistry three years later, after his graduation and being licensed to practice in North Carolina and Virginia, he located in Middlesex, N. C. Where he practiced for two years: He was married to Miss Sallie Freeman in 1913, who, with two children survive him, Sarah Freeman and Howard Cone.

In December, 1913, he moved to Williamston, N. C., where he bought out the office of Dr. White, who had moved to Scotland Neck; where he practiced most successfully until his death.

Dr. Cone joined the North Carolina Dental Society immediately after securing his license and was a constant and influential member until his untimely death. He was an active and valued member of Memorial Baptist Church, Shewarkee Masonic Lodge, Shriners, Kiwanis Club, and other civic organizations of the town.

He was well qualified in the profession that he chose for his life work; his manner invited confidence and inspired respect. He was kindly, sympathetic, tactful and well informed in current questions of the day, especially those in which his profession was concerned. While keeping well abreast of the professional thought he was more disposed to follow the dictates of his own judgment thoughtfully reached by experience and observation. He was a man of high educational ideals and honest to the core.

In the death of Doctor Cone the profession has lost one of its brightest lights, for truly his life was spent in the service of mankind. He lived true to his ideals, which were dominant in his heart. He was a positive character, with strong convictions, in defense of which he was outspoken. There mingled such kindness of heart and absolute loyalty to his friends, that those whose privilege it was to known him intimately will always feel the imprint of his personality on their lives.

During the hour of Doctor Cone's funeral all the business houses in Williamston were closed and more than forty of his professional associates closed their offices and traveled many miles to pay their last respects to their departed comrade.

Whereas, after a long, useful career of twenty-four years as practitioner, death has ended the life work of our fellow member. Percy Bunn Cone, who was universally loved and respected by the dental profession for his attainments and high standing.

Resolved: That we, the members of the Fifth District and the North Carolina Dental Societies, feel deeply his loss and hereby express our appreciation of his worth and his friendship.

Resolved: That a copy of these resolutions be spread upon the minutes, a copy sent to the members of his family and a copy published in the Proceedings of the North Carolina Dental Society.

Doctor Betts:

Dr. John H. Wheeler of Greensboro is recognized:

DR. J. E. WYCHE, D.D.S.

Dr. J. E. Wyche, who for four decades has been a prominent citizen of Greensboro, N. C., and who was recognized as a leader in the Dental Profession in his State, died July 2, 1933, at Wychewood, his ancestral home in Vance County, N. C., where he had gone for the summer.

The following day his remains were brought to Greensboro, N. C., and interred in Green Hill Cemetery, the dentists of the city serving as honorary pallbearers.

Doctor Wyche, son of the late Benjamin Wyche and Sarah Hunter Wyche, spent his early years at home in Vance County and received his education in the nearby schools. On reaching manhood he, having chosen dentistry as his profession, moved to Enfield, N. C., and studied two years under his uncle, Dr. Exum Hunter. Under this well known dentist and at the Baltimore College of Dentistry, under the tutelage of Doctor Wynder, he received the knowledge, training and inspiration that laid the foundation for the successful years that followed.

The first ten years after graduation Doctor Wyche practiced his profession in Oxford, N. C., moving from there to Greensboro in the year 1894, where he rounded out his half-century of practice.

Doctor Wyche was an ex-President of the North Carolina Dental Society.

He is survived by his wife and four children.

President Branch:

I recognize Dr. J. Martin Fleming, of Raleigh.

Dr. J. Martin Fleming:

DR. DELIA DIXON CARROLL

It seems fitting that more than ordinary notice should be taken of the passing of the only woman who has ever been elected to honorary membership in the North Carolina State Dental Society—not because of the fact that she was a woman, but because we recognize her outstanding character and high achievement in her chosen profession of medicine. So much has been written of her, both before and since her death, that it is difficult to say anything that has not already been well said and deservedly said; and yet we wish to record some personal sides of her character as we have known her during the years.

My earliest recollection of her was nearly forty years ago when we were both students returning to our respective schools for our senior year. She was a striking looking young woman of a commanding personality, and was on her way to New York for her last year in medicine, a thing almost unheard of at that time; a woman studying medicine, and we wondered what possibly could come of so startling a variation of the regular order of our limited idea of the so-called woman's sphere. Her life of successful practice has given full and complete answer to that question. She herself has said time and again that she never felt any handicap of sex. What might have been a handicap to some less talented woman was more than balanced by her extraordinary preparation and her natural bent for that work—she was a born physician.

Graduating in 1895 from the Woman's Medical College in New York, the only medical college at that time open to women, she spent several years as interne at different institutions—and then, thoroughly equipped professionally, she rounded out her education

by travel, making a leisurely tour around the world, seeing and observing everything.

Having completed this additional term of preparation she came to Raleigh to locate, and, on the opening of Meredith College in 1899, she became its resident physician, which position she still held at the time of her death. How well she succeeded in that position is attested by the fact that during the "flu" epidemic in the fall of 1918 she not only never lost a case but never even had a case in the whole college, so perfect was her plan of quarantine and prevention.

Immediately on locating in Raleigh she was invited to join the Raleigh Academy of Medicine and was at one time its president, the highest honor they could give to any of their members.

Soon after her coming to Raleigh she was married to Dr. Norwood G. Carroll, a popular member both of the State and Raleigh Dental Societies, and this union linked her closely with the dental profession which she ever recognized and consulted almost daily in her work. When the Raleigh dental organization was smaller, we met monthly in one another's homes and had dinner together—we have outgrown that now, as our numbers increased our homes became too small to accommodate us, but she and her husband, now retired from practice, have continued to have us at their home once each year and when we went she was the life of our meeting. Numbers of neighboring dentists who often met with us there will bear me out in that.

Some one has said that the charm of a home lies in its hospitality. With all her many accomplishments she never neglected the making of a home. Buying a few acres just out of the town, rough and rugged woods, she made it into one of the most attractive homes anywhere in the whole section. The home was built of logs—carefully selected and carefully put together. It contained many rooms and was a gem of architecture. The home was named "Nordel Hill"—Nordel being the first syllable of each of their given names (Norwood and Delia). It was a home of unending delights and all classes went there, governors, judges, teachers, preachers, doctors — all found a charm in its simple, unaffected hospitality and in the exchange of sparkling wit and quick repartee, free from any tinge of sarcasm. Nor were these the only ones to enjoy its hospitality—all classes went there, old people, young people, children, the rich, the poor, all found a cordial welcome.

The very day of her funeral the place was to have been open to the general public with an invitation to come and see the many rare flowers and shrubs, some of which were in bloom, in more or less profusion, almost the whole year round.

She died following an automobile accident in which she was not seriously hurt, but her health had not been the best for a year or two and, in her poor physical condition, the shock was too much for her. She and her intimate friends knew of this condition and yet under this strain she had continued to practice her profession with the same enthusiasm and ability which had always characterized her work.

The end came to her probably as she would have wished it—she had often expressed a desire to die "in the harness." She had her wish, but she will be missed by all classes.

She lived a life of service which will not soon be forgotten. To her husband, the close personal friend of many of us—goes the deep and abiding sympathy of this society.

J. Martin Fleming.

Doctor Betts:

A touch of deep sentiment fills us as we recall the memory of these members who have passed from us. When I recall the friends so linked together I have seen around me fall, like leaves in wintry weather, I feel like one who treads a lonesome banquet hall, whose lights deserted and garlands fled and all but him departed.

President Branch:

I think it is very fitting that we take this part of our program at the very opening in paying respect to the departed friends. I think it should not be put off until the last, but wisely put at the middle of the most important part of our program, because it is a very important part.

We have some visitors with us that we want to recognize: Doctor Bean; Dr. Harry Bear; Doctor Burns; my good friend Dr. Tally Beleau. (Applause.)

Before we go into the paper, there is just one word I want to say by way of explanation, or I will read it: It has been decided to omit the usual formal discussions, the Program-Clinic Committee agreeing with Doctor Thomas of Chicago that—"A man believed to be an authority on a subject can make his theme effective and convincing without extra aid. He can be happy without the flattery that usually goes with the first paragraph and the misunderstanding that usually fills the rest."

Now, you see why that is; that is so we can speed the thing up. Now let's be governed accordingly, and if there are any questions you want to know about just say it, but let's not have so much of this discussion that delays us. We are glad to have you fellows here.

We are now going to ask Doctor Squires to introduce our next speaker.

Doctor Squires:

Mr. President, ladies and gentlemen of the North Carolina Dental Society: It has been a big temptation in introducing the next speaker since he is a gentleman from my own town, to say a lot of nice personal things which I could say very easily about him, but I am just going to mention a few bare facts.

This gentleman is a past president of his medical society, district medical society; he is Professor of Pathology in the Wake Forest Medical School, one of the youngest if not the youngest fellows in the Medical College of Physicians; Chairman of the State Cancer Committee for the Medical Society; and I wish I had time to tell you something of the work that he is doing in that line, which is attracting attention from many states of the Union. But time will not permit of that.

But it gives me genuine pleasure to present to you Dr. C. C. Carpenter, of Wake Forest College. (Applause.)

Dr. C. C. Carpenter:

Doctor Branch, fellow members of the medical profession, ladies and gentlemen: I feel more inclined to say "fellow members of the medical profession" when I have such an opportunity as I had a few moments ago of hearing a scientific and scholarly address as that from your president. It seems to me so unfortunate that we began years ago by calling dentistry a separate profession. We know, as Doctor Branch so ably told you a few moments ago, that very few diseases are local in their manifestations, and it seems to me that it is a very difficult thing to think in terms of the mouth without thinking in terms of the general medical problem. And I am happy to learn that your president, among others, is considering dentistry a general medical problem. I appreciate this opportunity of coming to talk to you on a subject in which I am greatly interested.

Only a short time ago when a colleague of mine learned that I was interested in the subject of cancer, he said that it is becoming a fad to revive old and hopeless subjects!

MALIGNANCY OF THE ORAL CAVITY

By C. C. Carpenter, M.D., Wake Forest, N. C.

The constant increase in the number of deaths from cancer makes it imperative that the Medical Profession, including the specialty of dentistry, become better informed concerning its prevention, diagnosis and treatment. Aside from the fact that a good many more people reach the cancer age, and thereby make an apparent increase in its prevalence, there must be an actual increase in prevalence of the disease. In 1900 it was in sixth place as a cause of death, with a death rate of 63.0 per 100,000 population, and today it is in second place with a death rate of over 102 per 100,000. As interesting as it might be, we cannot afford to waste time with technical details concerning this increase, but must become more alert in stopping

its ravages. Professional men have been too prone to join the laity in taking a fatalistic attitude towards the disease without applying scientific facts in prevention and treatment. A recent report by a small group of physicians at the meeting of the American College of Surgeons showed 24,448 alive and well for from 5 to 25 years. These encouraging figures, however, are only found in the records of those who apply known scientific facts. Thirty-five years ago the same attitude prevailed concerning tuberculosis, and it ranked first as a cause of death. Today with an increased efficiency in early diagnosis, it ranks sixth as a cause of death, and it can no longer be referred to sneeringly as "The Captain of the Men of Death." Accordingly, if we stay constantly on the alert and detect the disease in its incipiency, cancer control would be greatly simplified. Dr. H. B. Whitehouse, noted English surgeon, states that in his country 60 per cent of all cases treated early in the progress of the disease have been cured; while a cure was obtained in only 6.7 per cent of advanced cases.

One too frequently hear well informed men make a great mystery of the cause of cancer. In reality, we mean that we are looking for a "fool proof" machine with a specific etiology and specific cure. Yet there are very few diseases so simple. Although we have not been able to find The Holy Grail, there are many facts known, that if properly applied would greatly check the malady. Our present scientific knowledge tells us that three definite factors operate to produce the disease, namely—chronic irritation; duration; and a susceptible host. The thing that makes the host susceptible is the greatest unknown factor. However, it is very likely that a chronic irritant, extending over a sufficient period of time, would result in a cancerous growth in the great majority of cases.

Assuming these facts to be true, the Dental Profession plays a major part in the control of cancer. It would be most presumptuous for me to remind this group that the prevention of chronic irritation is one of the great technical tasks of the dental surgeon. The fact that no more than 20 per cent of deaths from cancer are intra oral lesions is a tribute to your progress. Yet the prevention of approximately 5,000 needless deaths annually from lesions in this locality is your responsibility. Men whose practice is concerned with other branches of medicine are not properly trained, or inclined to properly examine the mouth.

There seems to be little doubt that buccal uncleanliness and infection are on the increase. This produces a continued injury and attempted repair of epithelial cells, especially along the alveolar ridge and on the tongue. Cancer may develop when these cells no longer grow in an orderly manner. The early lesion may appear as a papillary growth or a diffuse infiltration. It is of first importance that the dentist consider any of these infections as potential cancer cases, and urge his clientele to take them seriously. A surprising number of otherwise intelligent people show little concern over carrying in the mouth a microbic cess pool.

Equally as potent irritation may be expected from decayed, broken and ragged teeth, or one which is out of line but smooth. A chronic ulcer, or area of induration opposite such areas, should always be

regarded as suspicious. Loose and ill-fitting plates also, cause irritation and erosion of the delicate epithelium.

Leukoplakia is considered one of the most frequent intra-oral precancerous lesions. It is characterized by irregular, tough, white spots on the tongue or elsewhere in the mucosa of the mouth. There are usually multiple lesions. It may be readily recognized with the unaided eye. Various causes have been assigned to it. The most frequent cause at present is probably excessive smoking and an unclean mouth. Many authors assign syphilis as an important etiology. These areas should be carefully removed by proper oral hygiene, together with the removal of known etiological agents. It is gratifying to observe that dentists are using and recommending for their patients, fewer chemical agents. As a rule these are of no value in securing oral cleanliness. A thorough scrubbing with soap and water or baking soda is no doubt less irritating.

We have in tumors of the boney structures of the jaw a problem of even greater importance. The patient often notices a painless swelling or loose tooth with little concern. Aid is sought a little more often when the tumor is within the alveolar process, and the expanding growth causes pain. When these growths appear near a tooth socket or cause swelling of the gum, a careful X-ray study should be made before the tooth is extracted or the gum incised. In this locality we may see sarcoma, adamantinoma or epulis. The sarcoma is rapid in growth and delay in treatment often is fatal. Adamantinoma is locally malignant but generally benign. That is, it may not spread to distant parts. They appear first around the roots of the tooth. Epulis is a giant cell tumor that usually appears between the teeth and does not metastasize.

Cancer of the mouth that does not begin in the oral cavity proper forms a group of elusive and treacherous tumors. Epithelioma of the lip should be easily diagnosed. It usually appears as a painless scaliness or induration that fails to heal. Later an ulcer forms that bleeds easily. When the submental lymph nodes are involved the diagnosis is obvious. It should be made much earlier. In cancer of the floor of the mouth, tonsils or pharynx symptoms are usually absent. Any dental examination should include a thorough inspection of these areas, with special attention to crevices and unexposed parts. Any fissure, induration or ulceration should be regarded as malignant until proved not to be. The soft vascular tissue in this area affords a potent means of dissemination, and unless early diagnosed usually results fatally, in spite of intensive treatment.

In the oral cavity, as elsewhere, cancer begins as a local lesion, microscopic in size. If all cases could be diagnosed before the rapidly dividing cells spread to other parts by direct extension, or through the blood and lymph stream, the mortality would be very low. Also, the type of tumor corresponds to the tissue from which it arises. It may be from surface epithelium, glands, fibrous tissue, or bone. The only reliable means of treatment are excision and radiation. We know that a good many types are unaffected by radiation and excision is the treatment of choice. Others may be completely cured by the Roentgen Ray or radium and excision is undesirable. This means that the use of the microscope is indispensable

in the diagnosis and treatment of cancer. If we wait until the diagnosis can be made with the unaided eye, in the more malignant cases, treatment is very much like "locking the barn door after the horse has escaped." It is a very simple procedure to remove a small section of any suspicious lesion. The specimen should be placed in 10 per cent formalin and sent to the nearest laboratory. When the histological diagnosis is made, we are able to use the type of treatment that experience has taught us to be most effective for the type of lesion concerned.

A few moments ago I made the statement that excision and radiation are the only reliable means of treatment. This statement may be questioned when we recall a good many reported cures by the many little known cancer remedies. These are largely cases of mistaken diagnosis, or possibly spontaneous cures. In the literature we occasionally see reports of spontaneous cures. These may be due to occlusion of the blood supply, or the development of a relative general immunity. With this there is a spontaneous regression, but if the diagnosis has been proved by microscopic study of the tissue, the patient in most every case eventually dies of cancer.

In the final analysis, it is obvious that any disease that kills annually in the United States 125,000 people must be controlled in a scientific manner. This can be done if every practitioner of medicine, including the allied specialty of dentistry, uses in his practice the scientific facts known concerning this malady.

I thank you very much. (Applause.)

President Branch:

You know, it has been the custom for some years, gentlemen, for the dentists to send delegates to the Medical Society meeting and the physicians to send delegates to the Dental Society meeting. We are glad at this time to recognize Dr. H. B. Ivey, a physician, who is with us at this time, and we would be glad for Doctor Ivey to come forward and say a few words to us.

Doctor Ivey:

Mr. President, gentlemen of the North Carolina Dental Society. It is with a great deal of gratitude that I will attempt to say just a few words in a feeble way about this scholarly dissertation on cancer by my colleague, Doctor Carpenter of Wake Forest College.

It is with puculiar pleasure that I gather with you today, as a body of men representing one of the most important specialties, I consider, in medical science. You know, it might be with a good bit of embarrassment that when we think that not many years have elapsed since you men evoluted from a mechanical profession and that my profession evoluted from a narrow-minded bunch of alchemists and barbers. But today I am glad to say that we stand as a group, going hand in hand down the road to accomplish the same purpose.

I am not a pathologist and I am not capable of discussing the subject as I would like. We are not able to cover the entire field of medicine so we have to delegate different portions to different men, as the diseases of the mouth. The great service that I could render you would be to impress upon you the importance of pathological examination of growths of the mouth. Doctor Carpenter has very definitely enumerated these lesions of the mouth and shown you slides of these lesions, which I would say are some of the most beautiful slides of the mouth that I have ever seen. Unless you have attempted to make a photograph of lesions of the mouth, you could not realize to what pains he must have gone to to obtain these splendid pictures. But they are a wonderful group of pictures.

But what I would say to you is, that in the treatment of these lesions of the mouth, infections, and various other tumors that arise within the mouth, that after a short time if these growths do not respond to ordinary methods of treatment then it behooves you to section these growths. It is very little trouble to remove a small portion of tissue from a growth and send it in and find out. In sending this growth in you find out or accomplish a number of things: first you are sure whether or not you have a malignancy; second you get the type of this malignancy; third that will guide you in the handling of your case. Different types and different kinds of growth require different types of treatment.

Of course, treatment resolves itself down to one thing, to my mind, in the treatment of malignancy; and that is, destruction. It matters not what implements you use, you must destroy this malignant growth or you will not cure your patient.

I disagree with Doctor Carpenter somewhat in one remark that he made, that he did not believe that any malignant growth has ever been cured by these unknown, unrecognized remedies. The most of these remedies consist of agencies of destruction and the man that uses them usually knows no anatomy, but if he attempts to treat a growth he puts on a plenty, he goes wide, he destroys a lot of tissue, and usually he destroys a malignant growth.

When I was a student in medical college I had a professor of surgery who was particularly interested in the treatment of cancer. And I remember one thing that he said to us, I bet one thousand times in our year in surgery; and that was, "Gentlemen, when attempting to treat cancer, cut early, cut wide, and cut deep." The same thing applies today: Gentlemen, treat early, treat wide, and deep. That is the secret. Of course, Doctor Carpenter depends on his own methods of treatment, which consist of surgery and eradication, and surgery is a method of destruction. There are numbers of growths and many growths of the mouth that are better treated by surgery, causing a complete removal of the growth. But whatever method you use, you must use enough to destroy the growth. Of course, today the methods of eradication consist of radium and X-ray, and the physicians have been so kind as to tell us and to figure out for us the amount of eradication required for destruction of these growths, and when we attempt to treat malignancy we try to follow the methods outlined by these men that have given a life study to this particular work. In other words, if we are treating

a growth of the mouth we might use a combined method; we might use surgery and remove a portion of that growth and then probably implant radium in the base, and then as another precaution treat the lymphatics to take away these particles of growth to other portions of the body.

Of course, when you consider the treatment of lesions you must consider the location of these lesions and the location to the structures of your mouth; but the one important thing is this, to get your lesion early. Doctor Carpenter emphasized that fact; and if there is any one thing you should remember about what I say it would be that you remove your growth of the mouth or treat your mouth early. Now I would like to say that upon this rests the fate of thousands of North Carolinians as to whether they live or die. (Applause.)

President Branch:

I am going to ask Doctor Sinclair to introduce our next speaker.

Doctor Sinclair:

Mr. President, members of the Dental Society: We remember with pleasure last year of having Doctor Rickert of Ann Arbor with us. Ann Arbor, Michigan, is the home of scientific research and has been for many years. It was my pleasure in Chicago last February, at the mid-winter clinic, to attend a clinic by Doctor Brown. Doctor Brown and Doctor Ward are recognized all over internationally as men capable of scientific research in their line. They are recognized by the Bureau of Standards in Washington. And we are very fortunate in having a member of Ann Arbor research to be with us today, and I take pleasure in introducing Doctor Brown of Ann Arbor, Michigan. (Applause.)

Dr. R. K. Brown:

Members of the North Carolina Dental Society. That was a very flattering introduction. I don't think I can live up to it. It reminds me of the story they tell about President Hutchins of the University of Chicago, who was a rather young man. And it seemed that there was a banquet being given by the Chicago alumnæ of that school and there was a certain individual sitting in that banquet who did not care for President Hutchins. There was a very beautiful young lady sitting on this man's right and he was discussing with her as to why he didn't like President Hutchins, and went on down the line of these fancied faults of President Hutchins. And this woman

listened attentively and finally said, "Do you know who I am?" and he said "No." And she said, "Well, I am Mrs. Hutchins." And then he was nonplussed for a moment, and then he said to her, "Do you know who I am?" and she said "No, I don't," and he said "Well, thank God for that." (Laughter.) I am not quite in that same position. This lecture may be very dry but it is going to lead up to a practical application of amalgam work in my paper this evening. I have been interested in amalgam work and I know you men are interested. I know that North Carolina is very much interested in the dental health of its population, and there is no material today that we are going to call into use as we are the amalgam filling. The inlay is certainly a wonderful mechanism and it renders a health service, but for most of us the amalgam filling is going to be the means and methods of making restoration.

This paper is just an attempt to show what new information that we have gotten from the Bureau of Standards and what we have got in our own laboratory and what it has done for amalgam work—and first and foremost, I am not a scientist, I am a research worker only in this respect, that I take the findings of our man, Mr. Scott, who is a chemist, and try to apply them in the clinic. I haven't had the time to burn the midnight oil in microscopic work and test machinery; I am to a certain degree acquainted with them but Doctor Ward and Mr. Scott are much more able to discuss the pure research of this material than I am.

"THE EFFECT OF NEW INFORMATION ON THE MANIPULATION OF AMALGAM ALLOYS IN AMALGAM RESTORATION"

R. K. Brown, M.S., D.D.S., F.A.C.D.

The amalgam alloy problem is at present more nearly settled and is resting on a more rational basis than it has at any other time during its one hundred years of existence. The National Bureau of Standards through the introduction of a tentative Specification number one for dental amalgam alloys, which was adopted by the American Dental Association on October 10, 1929, has been a standardizing agency working toward constant improvement in this field.

It is fitting that Dr. Arthur W. Gray and Dr. Marcus L. Ward be mentioned as pioneer researchers in this field, and today they are doing a very valuable service to our profession by their continued investigations on dental amalgam alloys.

Criticism may be made of the statement that the Bureau may be viewed as a standardizing agency, and it may be said that the dentist's work will become a question of mere mechanics, but re-

member that with the operator's clinical application of the subject the personal equation will enter the picture, the danger will be relegated to the background, and individualism will be demonstrated in the following ways:

(1) In cavity preparation and design.

(2) In removal of decay and use of cement bases.

(3) In the pressure of amalgam on cavity walls due to packing technics.

(4) In the contours and anatomical carvings of the filling.

(5) In the correctness of contact point and inter-proximal space relations.

(6) In the polish and finish of the restoration and, in general in its individual superiority.[1]

The provisions of Specification No. 1 of the American Dental Association were based largely on the results of a questionnaire that had been sent to many dentists, in which they were asked to list the properties which they thought an amalgam alloy should possess. As a result of this survey the following properties of a good amalgam alloy were named in order of their importance:

(1) It must not show permanent shrinkage.

(2) It must not show large contraction at any time.

(3) It must show freedom from flow in the mouth.

(4) It must be reasonably high in crushing strength.

(5) It must be able to take and retain a polish.

(6) It must have a reasonably high tensile strength.

(7) It must not have a tendency to blacken the hand or mortar.

The original specification was based on these properties and was tentative. As time progressed and as more research and investigation were carried on, it was thought expedient to modify the specification and on January 1, 1934, Modified Specification No. 1 for Dental Amalgam alloys was given to the manufacturers and to the profession.[2] The most important modifications were as follows:

(1) A provision for protection against blackening of the alloy.

(2) A broadening of the chemical composition limits.

(3) The deletion of ultimate compressive strength requirements.

(4) The reduction of maximum flow value from 5 to 4 per cent.

(5) A change in dimensional setting expansion values from 1 to 10u to 3 to 13u per cm. at the end of a 24-hour period.

(6) The deletion of the allowed 4u maximum contraction to the first minimum.

Dr. Ward and I presented a paper and clinic on dental amalgams at the recent mid-winter meeting of the Chicago Dental Society, and at the close of the presentation the meeting was thrown open for general discussion. The question that seemed uppermost in the minds of the audience was: "Just what do the findings of the Bureau and the work of Ward and Gray mean to practitioners." I have been associated with Doctor Ward for many years, and at Michigan we have built our amalgam technic on his laboratory findings, giving it a scientific basis rather than an empirical one, with closely supervised practical application. Research and investigation in this field have affected the manipulation of amalgam alloys and the subject will be discussed with this thought in mind.

The alloys under consideration should have the following chemical composition range:

Silver (Ag.) 65 per cent minimum.
Tin (Sn.) 25 per cent minimum.
Copper (Cu.) 6 per cent maximum.
Zinc (Zn.) 2 per cent maximum.

The manufacturers whose products comply with Modified Specification No. 1—and there are at least 35 alloys that are acceptable today—should be patronized by the profession, for their products are of a superior and acceptable type. They should give explicit directions for the manipulation of their products based on the results of investigation and research.[3] Improper manipulation causes alloys close to the zero point of dimensional change to fall into the nonacceptable class.

The ratio or proportion of alloy and mercury to be used has been found to be very important. In general, 1½ times as much mercury (by weight) is used as alloy. The effect of using too much mercury in a filling is well known, volume change is excessive and flow is increased, while the edge strength of the material is markedly decreased. These proportions should be determined by the manufacturer and stated in the directions for using the alloy, and the dentist should use a weighing device to proportion the alloy and mercury before trituration.

Investigation has shown that the type of mortar and pestle used in trituration is important. The recent work of Ward[4] shows that a smooth mortar and pestle will give a mix of amalgam that will expand from 2 to 4u per cm. more than the same mix produced in a sand-blasted or roughened mortar and pestle, for the rough instrument gives more work to the alloy and overworking either in trituration or in mulling will cause shrinkage, while underworking will produce or tend to produce expansion.

The size of the alloy particles is also important in determining what type of mortar and pestle to use; for example, Baker's Aristalloy is very finely cut and to prevent overworking it, we should use a smooth mortar and pestle. On the other hand, Minimax 178 and Dee's Alloy are very coarsely cut and to secure proper trituration a sand-blasted mortar and pestle should be used.

Research has had more direct effect upon the trituration of the alloy and mercury than upon any other phase of technical procedures. The mixing time, both in the mortar and pestle and in the hand, must be described accurately; it is essential that the pen grasp be used on the pestle, with a light pressure when mixing in the mortar, for the type of mortar and pestle used will take care of the fineness or coarseness of the cut of the alloy. A light pressure is used on the pestle so that a desirable expansion is secured instead of a contraction of 2.0u or more when heavy pressure is exerted in trituration.

It has been found by Ward[4] that a speed of from 220 to 240 revolutions per minute should be used with the *pestle in the mortar* when triturating the alloy and the mercury. This has been determined as an average after having had many individuals mix for a minute at their accustomed speed, using a mortar with a

Veeder counter at its base which registered each revolution of the pestle.

The actual time of mixing should be given by the manufacturer based on what is considered a normal mix for his product. The *normal mix* differs from the *under* or *over mix*, and Ward and Scott[4] have given accurate descriptions of these mixes based upon the following conditions:

(1) Correct proportions of alloy and mercury were used, generally 5 parts of alloy to 8 parts of mercury. The same proportions were used for each of the three mixes to be described.

(2) A sand-blasted mortar and pestle was used.

(3) Pen grasp was used on the pestle with a speed of 220-240 revolutions per minute in the mortar.

(4) The mass was mulled in the hand at the rate of 120-130 revolutions per minute.

(5) A 2 mm. diameter plugger was used with 8 to 10 pounds packing pressure, as shown by the gauge designed by Ward.

In certain mixes in which these conditions were followed the mercury and the alloy were triturated from *25 to 40* seconds in the mortar with the pestle until the mass could be turned into the hand. It was then mulled in the hand for *15 to 20* seconds. No mercury was removed during hand mulling but any excess was removed during packing. The result was an *undermix* in which there was little breaking down of the alloy particles but a marked increase in expansion and flow.

In other mixes, which were also made under the above conditions, the mass was triturated from *35 to 50* seconds in the mortar and mulled in the hand *60 to 75* seconds. There was no crepitus evident; the mass could be rolled into a rope, and pieces could easily be broken off, and it would take discernible finger prints. Mercury was removed during the mulling if the mass became sloppy. The result was a *normal* mix. Considerable breaking down of the alloy particles occurred but this mix was the ideal one because it met the requirements of dimensional change and flow and made a tight plug which resisted leakage in air tests.

In other mixes the mass was triturated *one minute* in the mortar and mulled *two minutes* in the hand. Excess mercury was removed during the mulling if the mass became sloppy. The result was an *over-mix*, which was crisp and brittle—the mass was pasty and adhered to the sides of the mortar—marked crepitus was heard after mulling; and the mix showed varying degrees of shrinkage, but an increased flow. One alloy showed 16u variation between under and over-mixing, another 12u.

Blackening in the mortar or the hand denotes (1) the presence of metallic oxides or sulphides, showing that care was not exercised to prevent oxidation or contamination in melting or cutting the alloy during its manufacture; or (2) a very finely divided alloy as to particle size.[5] A comparative test for blackening can be made by taking normal mixes of various alloys and drawing them separately across a sheet of white paper.

During the mixing of the alloy and the mercury a question arises with respect to when and how excess mercury is to be expressed

from the mass. Ward[4] states that "when predetermined proportions of mercury and alloy are used throughout the mixing and mulling processes, there is from 2 to 4 microns more expansions with alloys that expand than there is if mercury is removed during mulling in the hand, and with alloys that shrink there will be from 2 to 4 microns less shrinkage. More mercury is retained in the set mass of amalgam when no mercury is removed during the mulling, provided other conditions are fixed." The amount of mercury used in the mixing and mulling processes, and the amount left in the set mass due to low packing pressure or to some other conditions are vital factors in dimensional change.

The excess mercury is best expressed after hand mulling and just before the amalgam is placed in the cavity for condensing; thus each piece retains its excess mercury until needed, when it is expressed by hand.

Packing and packing pressure affect the finished restoration. A packing pressure of 8 to 10 pounds on a smooth plugger 2 mm. in diameter was used in all of the tests conducted by Ward and Scott,[4] for this pressure admits of application in the mouth. Variations in packing pressure were noted by Ward as follows:

(1) Expansion decreases with increased packing pressure from 0 to approximately 16,000 pounds per square inch.

(2) At 32,000 pounds per square inch expansion returns and increases with increase in packing pressure.

(3) The percentage of mercury decreases with increase in packing pressure up to the maximum number of pounds used. It seemed impossible to reduce the mercury content below *28.3 per cent.*

(4) Expansion increases and decreases with increase and decrease in percentages of mercury.

(5) In average cases if amalgam is just jarred into the specimen *59.89 per cent* of mercury is present, while packing with *19.48 pounds* on a *2 mm. plugger* (4000 pounds pressure per square inch) the limit of range possible in the mouth, 47.47 per cent mercury is left.

The methods of packing amalgam are many and varied, but the technic given by Dr. W. E. Harper produces excellent results under the following conditions: A plastic mix is used; the mass is tamped into the cavity and condensed in an orderly manner; and finally the cavity walls are stepped with small pluggers or Harper's burnishing technic is used, for it is desirable to remove all of the mercury possible during the packing of the amalgam into the cavity and yet make a tight plug with desirable edge strength, remembering that crepitus denotes loss of adaptable plasticity, with a tendency toward leakage.

It is well to note that when mercury is added to a mix to soften it, the first drop gives a product whose strength decreases 80 to 90 per cent. Souder and Peters have stated that probably no other phase in producing an amalgam restoration is subject to greater carelessness than the manipulation of the alloy and mercury.[6]

The property of flow in amalgams is being studied seriously for the first time in its history; knowledge of this property has been limited and the specification calling for a maximum of 4 per cent of flow has no scientific basis. It is assumed that flow is the yield of

amalgam when compressed and that beyond certain limits it is permanent. It causes contact points to disappear, the filling to bulge over the margins, with frequent cervical overhangs, and to distend in the cavity which has been called spheroiding. At present an alloy that will show little flow will give a filling with increased brittleness and a loss of edge strength.

Clinically, the constant striking on an amalgam by the point of a cusp from a tooth in the opposing jaw may apply an effective load of several thousand pounds per square inch, even though the gross pressure is only a few pounds. The smallness of the area of contact has the effect of intensifying the impacts when considered in terms of pounds per square inch, for it is like tapping the head of a rivet with light blows for a short time with the result that the cylindrical head of the rivet changes to a flat bur. Flow may be caused by excess tin in the formula of an alloy as well as by an excess amount of mercury left in the restoration. The cavity preparations advocated for amalgams today are the result of operators' efforts to provide a sufficient bulk of material to restrict flow, for this is the greatest weakness of amalgam.

Doctor Ward is at present studying flow. He has found that pure gold will flow at a uniform rate but that its flow at the end of twenty-four hours is the same as it is after thirty days. It is greater for gold than for amalgam for the first twenty-four hours; then amalgam leaves it far behind. Test specimens in his laboratory flowed continuously for a thirty-day period, reaching their maximum after a five-day period, and then steadily declining in amount. Laboratory conditions for testing flow do not reproduce mouth conditions, this presents a fertile field for the investigator for stresses or pressures in the mouth are not continuous; they are intermittent and subject to temperature variation.

It is essential that the effect of temperature change on amalgam in the mouth be understood. The resulting changes in fillings due to this cause must not be attributed to flow, for the bulging or spheroiding of gingival third amalgams is often due to temperature change in the mouth. These cavities are shallow, the amalgam, while being packed, slips from side to side, and the excess mercury is not removed; the resulting marked expansions are *increased* by temperature changes. Bronner[7] has designed amalgam condensers for use in these gingival third cavities that will enable the operator to condense the amalgam more thoroughly than was previously possible.

The expansion or shrinkage of amalgam with temperature change is three times as great as that of the tooth over a range of 50° C. (122° F.), the temperature range, according to Souder and Peters,[6] to which metallic fillings are subjected in the mouth. Plastic amalgam when placed in a tooth will not seal the cavity when both the cavity and amalgam are cooled below body temperature, unless, during the hardening process the amalgam expands and compresses the dentin.

This compression of the dentin causes the cavity to follow or close in on the filling when the latter is cooled by cold food or drinks. The amalgam, if cooled, shrinks three times as fast as the tooth's

normal shrinkage so it is necessary to have this follow-up of dentin. The crystallization expansion of the amalgam during the setting period must be at least 3u per cm. or 3 parts in 10,000, and a minimum of 6 to 8u expansion is much better.

Souder and Peters[6] state further "that the differential expansions of materials depend upon the temperature range, size of cavity, elasticity of tooth substance and material." If, therefore, we have perfect adaptation and no stress at the lower mouth temperature two conditions are possible:

(1) The elasticity of the tooth and compressibility of the material may be such that perfect adaptation is maintained or

(2) The rigidity of the tooth and plasticity of the material may be such that there will be a flow of material in the only free direction, causing a spheroiding or bulging over the cavity.

If the filling takes a permanent set at the higher temperature, on returning to the lower temperature, all materials having undergone free contraction, there is a possibility of a 4u separation around the cavity. This explains the failures of our restorations in some mouths with highly calcified teeth.

Other properties of alloys are not of particular interest to the practitioner. Acceptable alloys have a Brinnell hardness number of from 45 to 65, the same range possessed by the soft inlay golds. Tensile strength was not considered important but it is about 10 per cent of the compressive strength. To increase this property alloys would show increased compressive strength, increased flow, and permanent shrinkage so it is not considered an essential or important property at the present time.

Amalgams are subjected to stresses and to crushing and shearing loads that throw parts of the filling into tension and other parts into compression, especially in thin sections of the filling; consequently, failure often results. The operator should do all that is possible to secure bulk in the filling and thus lessen flow and increase edge strength. This last property seems to be due to a combination of hardness, tensile strength, and crushing strength, and is important. Bevels on a cavity are dangerous unless they go one-half the depth of the cavity; with the inlay type of cavity preparation, however, as adapted to amalgam, bevels are unnecessary, except an outward bevel on the cervical floor and when protecting cusps.

Mercury in amalgams does not vaporize in the mouth, and amalgams do not wear or dissolve rapidly; if they did, it would be in such small amounts that it would be far from the toxic dose, so mercury is not considered poisonous in dental amalgams.[5] This has been a controversy of many years standing but it can now be forgotten.

Teeth will not discolor when filled with amalgam unless leakage or disintegration of the filling occurs. Discoloration is due to the formation of sulphides from food decomposition in the mouth or its fermentation, which reacts on the silver and copper of the amalgam to form salts that may be absorbed into the dentinal tubules, if leakage is present.

Let us regard research as a lamp that has been filled and lighted to guide us in our efforts to give health service to our fellow-men.

Through the correlation of scientific investigations with clinical procedures the health service rendered by our various filling materials will be greatly enhanced, and we will taste of the sweets of success and satisfaction while pursuing our daily tasks. I thank you very much. (Much applause.)

BIBLIOGRAPHY

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[2]"Specifications and Certifications for Dental Materials," G. C. Paffenbarger and W. T. Sweeney, J.A.D.A., April, 1934, pp. 658-664.

[3]"A Third Survey of Dental Amalgam Alloys," Geo. C. Paffenbarger and W. T. Sweeney, J.A.D.A., April, 1933, pp. 649-652.

[4]"Effects of Variations in Manipulation on Dimensional Changes, Crushing Strength and Flow of Amalgams," M. L. Ward and E. O. Scott, J.A.D.A., Oct. 1932, pp. 1683-1705.

[5]"Amalgam Technic, Dependable and Dangerous Practices," N. O. Taylor, J.A.D.A., Oct., 1930, Vol. 17, pp. 1880-1889.

[6]Bureau of Standards Technologic Paper No. 157, "An Investigation of the Physical Properties of Dental Materials," Wilmer H. Souder and Chauncey H. Peters, May 22, 1920.

[7]"Revolving Motion vs. Rectilinear Motion," Finn J. Bronner, Dental Cosmos, May, 1933, pp. 491-496.

[8]"Is Mercury Poisonous in Dental Amalgam Restorations?" Wilmer H. Souder and W. T. Sweeney, Dental Cosmos, 73:1145-1152, Dec., 1931.

President Branch:

Well, gentlemen, that brings the morning session to a close. Now, in bringing the morning session to a close, we will open the first meeting of the House of Delegates.

Meeting adjourned at 12:45 p.m.

FIRST DAY—MONDAY, JUNE 18, 1934

Afternoon Session

Meeting of House of Delegates

The meeting of the House of Delegates was called to order at 12:45 o'clock p.m., by President Branch.

PRESENT

Officers of the Society

Ernest A. Branch, *President*.....Raleigh
L. M. Edwards, *President-Elect*.....Durham
D. L. Pridgen, *Secretary-Treasurer*.....Fayetteville

EXECUTIVE COMMITTEE

R. M. Olive.....Fayetteville
N. Sheffield.....Greensboro

ETHICS COMMITTEE

J. Martin Fleming, *Chairman*.....Raleigh
J. C. Watkins.....Winston-Salem
J. W. Whitehead.....Smithfield

BOARD OF EXAMINERS

Jno. A. McClung.....Winston-Salem
E. B. Howle.....Raleigh

FIRST DISTRICT

A. C. Current.....Gastonia
R. A. Little.....Asheville
Pitt Beam, for S. E. Moser.....Gastonia
A. Abernathy, for J. A. Young.....Newton
Doctor Young, for C. S. McCall.....Forest City.

SECOND DISTRICT

Harry Keel.....Winston-Salem
C. M. Parks.....Winston-Salem
D. W. Holcomb.....Winston-Salem

THIRD DISTRICT

C. I. Miller.....Albemarle
T. E. Sikes.....Greensboro
J. T. Lasley.....Greensboro
O. L. Presnell.....Asheboro
D. K. Lockhart.....Durham

FOURTH DISTRICT

I. H. Hoyle.....Henderson
L. J. Moore.....St. Pauls
J. W. Whitehead.....Smithfield
Wilbert Jackson.....Clinton

FIFTH DISTRICT

H. K. Thompson.....Wilmington
W. L. Hand.....New Bern
H. E. Nixon.....Elizabeth City

G. Fred Hale, *Editor-Publisher*.....Raleigh

President Branch:

I don't know when I ever heard a roll call when so many were present as there are at this meeting. That is a splendid record.

What is the first order of business. Are there any outstanding reports or unfinished business from last year?

Are there any new applications to come in to the secretary?

Dr. J. T. Lasley:

I can report from my district only, that we have had ten reinstatements from the five-dollar proposition that we have had on this year.

President Branch:

Are there any committees to report? I recognize Dr. Fred Hale.

Dr. Fred Hale:

The BULLETIN of the North Carolina Dental Society, discriminating in the quality and amount of advertising, closes the fiscal year with a balance in the bank. For the past few years a saving to the General Fund of the Society for the printing of the program for the annual meeting, has been effected by the BULLETIN assuming this obligation.

Our BULLETIN received complimentary mention in the report of Journalism of the American College of Dentists. At the last meeting of the American Association of Dental Editors the American College of Dentists made five recommendations with regard to advertising policies in nonproprietary journals. I am happy to say that these recommendations have been policies of our BULLETIN for the past three years.

Suggestions are courted for the betterment of our BULLETIN and to make it a more valuable periodical for the profession. Constructive criticism is always welcome.

Now, may I ask permission to put in a supplemental report to take care of accounts receivable and accounts paid out between now and the time the BULLETIN will go to press. (Applause.)

REPORT OF EDITOR-PUBLISHER

Balance in Bank August 1, 1933	$ 26.06

RECEIPTS 1933-34

1933	
Oct. 23—Harris Dental Co	$ 15.00
Nov. 13—Raleigh Dental Laboratory	25.00
Merrimon Insurance Agency	10.00
Rothstein Dental Laboratory	15.00
Nov. 15—Manly Sparks	7.50
Nov. 20—Pycope	25.00
Dec. 22—Fleming Dental Laboratory	7.50

1934			
Mar. 7—Raleigh Dental Laboratory	$	25.00	
Merrimon Insurance Agency		10.00	
Mar. 12—Pycope		25.00	
Mar. 19—Manly Sparks		7.50	
Apr. 9—Rothstein Dental Laboratory		15.00	
Apr. 9—Dividend Commercial Bank		8.37	
Apr. 13—Woodward Prosthetic Laboratory		15.00	
Apr. 16—Corega Chemical Co.		25.00	
Apr. 30—Thompson Dental Company		15.00	
May 10—MacMillan & Connor		8.00	
May 10—Friendly Cafeteria		8.00	
May 14—J. B. Vaught, Jr., Laboratory		15.00	
June 7—Raleigh Dental Laboratory		25.00	
Powers & Anderson		15.00	
Dental Supply		25.00	
June 11—Manly Sparks		8.00	
June 13—Eberhart Conway		15.00	
Pycope		25.00	
June 15—Rothstein Dental Laboratory		15.00	
W. D. MacMillan		8.00	
Crescent Motor Co.		8.00	
June 22—Hotel Cape Fear		15.00	
Bristol-Myers		25.00	$ 498.93

DISBURSEMENTS 1933-1934

1933			
Oct. 7—Stamps	$	3.00	
Oct. 11—Postmaster mailing BULLETINS		5.00	
Nov. 2—Postmaster mailing BULLETINS		5.00	
Dec. 6—Bynum Printing Co.		100.00	
1934			
Jan. 18—Cash, Stamps	$	3.00	
Apr. 4—Bynum Printing Co.		75.00	
Apr. 16—Cash, Stamps and Notary fees		4.00	
Apr. 27—Bynum Printing Co.		60.16	
May 21—Cash, Stamps		3.00	
Bank service charge		1.54	
June 16—Bynum Printing Co.		175.00	
June 28—Telephone and Miscellaneous		4.55	
June 28—Bynum Printing Co.		40.26	
July 10—American Asso. Dental Editors		5.00	$ 480.15
Balance in Bank August 1, 1934			$ 18.78

Accounts Receivable:

Fleming Dental Laboratory	$	15.00	
Ocean Inn		8.00	
Seashore Hotel		15.00	$ 38.00

Accounts Payable:

None.

President Branch:

Without objection, the chair will grant that permission. We are always glad to have reports when the money is on the right side!

Is there any new business? If not, a motion is in order to adjourn this meeting.

The meeting, upon motion duly made and seconded, adjourned at 1:00 o'clock p.m., Monday, June 18, 1934.

FIRST DAY—MONDAY, JUNE 18, 1934

Evening Session

The meeting was called to order at 8:15 o'clock by President Branch.

President Branch:

Gentlemen, the night meeting will please come to order. I will ask Doctor Sikes to introduce the speaker.

Dr. T. E. Sikes:

Mr. President, members of the North Carolina Dental Society: It was my privilege in 1916 to attend Vanderbilt University with our guest speaker for the evening. This young man has always been a student, a thorough and conscientious student. Men are classified into two groups, leaders and followers: This man is truly a leader in his chosen field, and he has made for himself a well-known name, due to his skill and ability, throughout the United States.

It is my happy privilege to introduce, without further comment, Tom Conner, of Atlanta, Georgia. (Applause.)

Dr. Thomas Conner:

Mr. Chairman, Doctor Sikes, gentlemen: It is truly like being home to talk to this group of men. It seems to me that I run into more acquaintances here than I do in Georgia. I hate to admit that I have been teaching long enough to have had some of these men for students, because it makes me realize that I am moving along and that I will be the "old doctor" before long.

I really hesitated to accept an invitation to come to this organization because there are so many of you men who have had post-graduate courses and who have given clinics all over the country in this particular line of work that I am really embarrassed to

appear before you. Because I feel that you are in a position to really tell practitioners what they need than I am.

Now I have a few moving picture films of interesting cases that I have had the privilege of seeing during the last few years, and as we go along I will attempt to explain some of these pictures. Some of them you have seen, some of them you haven't, but the ones that you have seen I think bring to you a message of fundamentals in doing cysts.

This first picture shows some cysts that were done five or six years ago and we still do them the same way. I haven't been successful in doing a cyst of any size in closing the wound up; I have had more success in packing the wound and letting it heal from the bottom. I had rather take three or four or even five weeks or six and see that wound heal from the bottom and know that we have healthy tissue filling that cavity than to close it up and then make an X-ray in six months to see if it has filled in. I think it is a little more conservative for the man who doesn't do a great deal of oral surgery.

Now this is the cyst you saw the X-ray picture of just a minute ago. It has been customary in some locations to remove this with incisors, leading into the cyst cavity and breaking down the alveola tissue and leaving a wound or depression that is very hard to make a restoration in. When I was in general dentistry I had to make a few restorations for Doctor Hinman's patients where the alveola had been removed in the operation to get access to the cyst sac. I know most of you men do this operation now, but as I say, some of you don't, because I see cases that have been operated where this tissue was broken down. It is very seldom necessary to break this alveola tissue down; you can make an incision here when the teeth are involved. Here we are breaking down this labial plate of bone and we use this mallet and chisel. We use a mallet and chisel in part of this area and we smooth up the rough spicules. We take Doctor Bogle's curette and clean out the spicules so that the field will be clean. Now we take one of Doctor Fred Moseley's scraper-type curettes and with blade reversed we peel this cyst sac out, or dissect it from its attachment. Now this picture was made about six years ago and we didn't have a suction machine at that time. We have one at present that you will see a little later on that keeps these fields perfectly dry. This picture was made by two physicians and it took them about an hour to get ready before we started the operation, so it's hurting this patient a little. Now we take a hemostat and pull this sac out. You see that has been taken out through a window that is made in the labial plate, this window is made big enough to see into that cavity. As you treat this you can look in and see the healthy granulation that is filling in there. Now you see the nerves and blood vessels. You see we have made a tubular canal and you have the blood vessels and nerves here, as a rule pushed in front of the sac. You can see the nerves and blood vessels here, so I don't think it is a good idea to take a curette and run it around the cyst in the mandible or in the maxilla in this region, because you get your blood vessels and nerves here. Now we take the cotton out of the socket, that was

simply placed in there immediately after extraction so we wouldn't have so much bleeding, and later on in the operation you can curette these sockets. We make our incision a little wider than is necessary. Here you want to take a file or a chisel or burr, whatever you want to use, and smooth this margin, this alveola tissue, so that when you take the gauze out of that socket cavity it will not catch on the rough margin. This is whiskers; it isn't a fly! Now we are going to put a suture on each side so as to leave the window in the middle to take your dressing from. For that sewing of the suture I use a needle, a half-round cutting needle, and a hemostat. This is a case ten days after the operation. The man went the same day we did the operation and had his denture put in, replacement. We change this gauze and we do not use any irrigation solution on this type. We merely use cotton and wipe the cavity out, as you see there, leaving it perfectly dry, and put in this dry piece of iodoform gauze. Now you can see the teeth of usual length and you have normal alveola tissue and the patient has not been disfigured as far as his looks are concerned. Now we show you some lantern slides of this case later on, where the teeth were not extracted.

This is the first case that I did of a big cyst where we did remove the teeth immediately after the cyst. Here is the cavity about three or four weeks after we did this. It involved most of his pallet and the roof and the bicuspids were visible. But we played along with this case about three months—it has been about four years now—and the boy's teeth are perfectly all right. This is another little cyst. You might be able to operate these cases through the socket, however, I think that you are a little more positive of removing the area involved or the cyst sac if you make a window in this as you did in the other case. I think, of course, where you have a pulpless tooth that is the definite cause of the cyst why it's best to extract it. However, where the teeth are vital, I think it is worth taking a chance on saving them. Now we retract this tissue up, we don't disturb this bone tissue here, the bone is very thin in some of them. So we want to preserve that bone and periosteum filling in. The smaller the cyst as a rule the thicker the labial plate. We use a chisel to make that window. We are dissecting the sac away from the tissue and taking a hemostat after that is done, because I don't like to go all the way back of the cyst because you may run into nerves and blood vessels. It is unnecessary to do that. Now with one of those curettes we simply go around the artefact or the bone tissue, we don't go down into the bone. If you never made a picture—I show you this because that looks rough and ragged, and I thought I was being very gentle with him, but if you ever have a photograph made, a picture of yourself, operating, why it will bring out some of your very weak points. We curette this socket; we are going to fill this in and pack it and let it heal from within.

Now here we have an abscess as a result of an infected bicuspid. We are going to drain the external cause. This is a man in his forties, and it is certainly much more conservative to open this. The man has been out of or out from work for about two weeks and he was not referred to me immediately. We have a drain intra-

orally. The tooth was extracted and each day the pus was aspirated, the thinner pus from this cavity and yet the heavier pus simply stayed in this socket. Now it's nice to keep your abscess draining intra-orally but it isn't always practical. It seems more practical to open this outside, and use just simply dry gauze packed in this socket and taken out and repeated two or three times at a sitting, and get the cavity as dry as possible. We do those frequently under ethyl-chloride spray. You can see the spray here that is going off. This man probably had fifteen or twenty abscesses lasting over a period of a year. He had been to a half-dozen men for treatment, one of those wandering stones, and I don't know whether he is dead or alive now. He didn't stay with me until the work was finished. He had an osteomyelitis and it involved the entire mandible. But here you have the mal-occlusion. This is an X-ray of the left side, these teeth were left in to see just what would happen. I don't know how long the teeth stayed like that, because, as I say, he might have died or gone somewhere else, I only saw him a few times.

This is a slide of a third molar that was leaning, we have the pathological tract here and sequestrum. And this is your third molar that prevents the ramus from riding high. This is a case where we have a slide, and it is only a few feet. You see a drain here, over his ear, and another one here, here and here and here. This man had the infection following an extraction of a tooth. Now let me say that I don't think this infection here was caused by the tooth. I think most of these infections were in the process of developing before the tooth was extracted. That is my candid opinion. We fix those sinuses like this and let them heal very slowly. Now this is a case, there you see a wound that is draining from above his ear to this point. He also has an opening from this point intra-orally. Now the dressing was so foul that when we wanted to change this we would tie this string to it and pull the oral dressing out in this position that is aspirated. It keeps this field nice and clean. That is the old dressing there. We tie the upper end of this string to this gauze and pull it through the opening, just like a gun cleaner, pulling out a few small spicules and the heavy pus that will not drain by these dressings. You see how that is pulled through, and in this manner. We get a hemostat hold of the string and just wipe that cavity out. You leave this dressing in until then and we will take a string, a piece of cord or dental floss, something that is strong, and tie it to this end and pull it through and repeat. Now we move this rubber tube, drain, it's really a rubber drain, soft rubber, back and forth, and aspirate. We are going to discuss these cases tomorrow, I wanted to show you how that dressing is changed, though. It is the only way I ever worked one, is that way, but it's been very satisfactory. These cases of osteomyelitis are an awful mess and I hate to have them come in our office.

Now we are going to get on a little different line. The last reel will be on cancers. We are going to carry this distally and we are to make a buccal application. We are going to use an instrument that is sharp enough for this job. We here make a buccal application.

Now let me say that this picture was made several years ago and I was right proud of it then, but at the present time I am not so proud as I once was; but that shows you this technique most beautifully. The doctor used this picture in his school up there for four or five years but he would not go into the movie game until he thought he could make one that was practically perfect, and he has made one really that I think is by far the greatest teaching instructor that I have ever seen. When you hold this instrument you have got to have a sharp instrument under control. Here we have some resistance, you can't carry that tooth distally far enough to free the root end. You can cut this bone with the hand pressure chisel or a mallet or a burr, whatever instrument you prefer. I wouldn't have you change if you are getting results. The main thing is to cut enough bone on it distally here to allow you to carry that tooth distally far enough to compensate for the slight distal curve of the roots, in this particular case or in other cases, to free this marginal ridge of your second molar. You must cut this bone here from buccal to lingual wall far enough to allow it to be carried distally, of course without fracturing your lingual plate. And frequently you are cutting some of the buccal bone here. You can do that again with any instrument you like. There is a little too much buccal plate there to go through with your elevator, you have got to cut there for access to the buccal cementum. But you are using your wedge and going to carry that tooth distally, as you see here. Then we are going to make that buccal application at this point, using this method for your fulcrum, raising that tooth up and out of the socket.

Now here is one that infection has destroyed the bone on the distal. You don't have to worry about that, you are going to raise it upward and backward, you are going to increase the size of your wedge; select a wedge for this point just a little thicker than the cavity so that when you push it into the cavity you will have it in contact with the buccal tissue. Now, if you will carry this message home, with you, if you don't already have it, it will be a big help to you. You can use the same technique there that you use on your third molar, if you like. You can separate these first molar roots with the same elevator. This is an old dry specimen that was very brittle. You can go down to this mesial socket and use this for a fulcrum and take the distal root with it. Now here is a bicuspid and that instrument is going right down into that surface.

We have one more reel. This is an epulis. The patient was a man in his late forties; you see he couldn't get his lips together. We were not sure that it had not developed to the point where he had malignancy. These are the cuspids and you see the attachment there to the epulis. Now we are going to make an incision parallel with the lingual gingival margin and remove the periosteum along the lingual of the alveola tissue and across the intervening area and over to the labial periosteum. We were a little more radical than we would have been had we not known that part of the tumor was malignant. However, it proved that it was benign. Making an incision up over the apices; the reason we left that lingual alveola tissue is because we found no destruction, the tissue looked healthy,

though we left it in order that he might have a ridge for his denture to rest on. But to think of a man going around for several years with a thing in his mouth that he thought was a cancer, a mountaineer of north Georgia. His wife was dead and he was mother and father for his small children, and he thought that when he was operated on that it would be the end. He had never found anybody or known of anybody that had gotten well of a cancer and he was sure that that was it. And he was about the happiest man I think I ever saw when he learned that he did not have a cancer. He had a normal ridge there, a ridge that was perfectly satisfactory for a denture.

This is a cancer of the lower lip, in the early stages. This treatment was done at the cancer clinic at Atlanta, the Steiner Clinic. And Doctor Stuart is preparing this model crown compound for his lip and will use that as his vehicle to carry his radium in contact with the cancer. That is dental modeling compound. You can see the imprint, and as he can see the imprint of the cancer he hollows that out slightly with a gouge. This radium energy is pumped off in little glass tubes and then put into little silver tubes. And the silver tube is implanted into the compound. You can see those little tubes. This is put in silver tubes in order to filter out some of the soft ray that would destroy the surrounding tissue. A cancer of that size, the number of tubes put in there would be left about forty-five minutes. Now those cases, I have seen them for a number of years, and they got well.

This man had a cancer of eight years standing; a horrible affair. Really he looked like he was a monstrosity. This man eight, nine, or ten years ago had a cancer on his lip as small as the one you saw a minute ago, certainly a curable thing, because if it hadn't been a very slow developing thing he would have been dead long ago. He was from Alabama. He saw a physician who referred him to one of the neighboring cities, but he didn't have four hundred dollars to pay for the application of the radium. He went home and his next resort was the Indian herb doctor. He might have been dead if it hadn't been for the Indian doctor, but it was about seven years before he came to the cancer clinic. This patient is anæsthetized with chloroform and this is an actual soldering iron, about the size of an ordinary smoothing iron. Doctor Stuart is doing this operation; he is outlining on the skin where he is going to take the soft tissue, he is going to cut this around and remove that flap. Now, I am showing you this picture, gentlemen, just as an educational thing, because this, I am quite positive, could have been prevented. But it is a thing that is certainly not curable without expert attention. And when a man with no means is turned away from an office or a hospital to go off and die, you might say, with a thing like that, it isn't right. We all run patients away from our office occasionally on account of fees, but let's never be guilty of running one away who is in such a condition that he is going to die if something isn't done. This is the flap of soft tissue that was removed. He had some involvement of the labial bone. This is cancerous tissue here. They are going to take an actual soldering iron and here he is cauterizing that bone. Now that looks bad, but

for this man, and for myself, I would rather have it than be dead. If we could only keep from paying the extreme price. That soldering iron burns the enamel on the teeth and everything; that tissue is cooked; but the remarkable part of this operation is that this man was dismissed from the hospital in four days. He had no pain. It is unbelievable, but in four days that man was dismissed from the hospital and I made a picture that you will see in just a minute, in three weeks on his return. Now this gauze dressing, a strip of vaselin gauze is placed around this. Now here he is three weeks after, he is really extremely happy there. This tissue has healed beautifully. He has a sequestrum right here. Now this has been a little over two years ago; about six months ago we did a plastic on him. He has a lip, and I was out of town when they did this plastic, and he is coming back to the clinic in a few weeks from now and I hope to get a picture of him after the plastic surgery has been done.

Now this is a case, when I made that picture I thought it was gangrenous, it is debatable whether it is gangrenous or syphilis. That is a Negro boy that is eighteen years old. You see here this entire area here is affected. I am trying to lead these things up to you because these things are preventable. There is no reason why this man should ever have gotten into the condition he was in, or the previous one either. We have got to do more preventive dentistry if we render our real service to humanity. This boy, all of his nose was gone, and his ethmoid, you can see the ethmoid cells of course, you see the roots here, and it's too late to do anything for him. He can't drink, he can't eat, all he can do is to pour the liquids on his tongue and let it run down until he can swallow.

Now this next case is a woman in her early seventies. You see a slight swelling here. You see her chin is deflected to the right side of her face. You see how many wrinkles there are on this side. By looking at both sides and seeing the way her chin is deflected to the right anybody that has ever done any of these cases realize that it was a dislocated left. This reduction was attempted under gas oxygen. It was of six weeks standing. I started this down and back movement. I had never seen a case, I knew of cases, I had read of them in the books the night before that, and some of those cases had to be reduced by direct operation. But I didn't want to take this old woman to the hospital and I thought I could reduce it in the office under gas oxygen. We flopped around there; I got in front of it, the usual thing, and it didn't work. I am killing time, I am playing, because I don't know what I am doing—I am on my way though. I got down on my knees to her. That didn't work, either. I got around behind it. I told the nurse to take off the mask; she looked worse than she did when I started. (Laughter.) I got around behind her and started doing what I had tried to do at first. Now, it slipped back in place and she is scared to talk or look around for fear it will jump out again. Look at that grip! She is holding on. See how much whiter it makes her. (Laughter.) I would not dare let her move her jaw. That thing was dislocated at night in her sleep. She woke up with it that way. I put enough adhesive tape on there to *hold* the mandible in place.

(Laughter.) She came back in a week and she wouldn't let me remove the adhesive tape. She said, "Doctor, I feel so good, just let it stay, I will take it off when I get back home." I don't know how long she kept it on there, but I saw her two years after that and it was off—so it didn't stay on quite two years. (Laughter.) (Applause.)

Now, may I have all the lights. I want to discuss this last case, this old woman. There is a case where we get a great deal of criticism from members of our profession and also occasionally from members of the medical profession, because we don't do the right thing at the right time. This patient came from a neighboring town. The primary reason for her being my patient was that she was my cook's mama, and I didn't want my cook to leave home. So I had the patient came up to make a visit. But this woman from the neighboring town was being treated by a physician and the treatment was massage with a salve. If you can imagine anything worse than treating a dislocated mandible with ointment, I would like to know what it is! When they get on my neck about doing things I shouldn't do, why I just show them this picture and let them know that there are some medical doctors that are almost as bad as the dentists. I must say that in our town, though, and community, we do get coöperation, I think more from them than I give the medical profession.

Now on this cancer work—I don't know a thing about cancers; you don't and I don't, and I don't know anybody who does—other than if you get them early some of them will get well. I would say that a very, very large per cent of those early lesions on the lip and on the end of the tongue and on the gum will respond to proper treatment, the treatment that is considered proper today. Let's don't fall down on the job and fail to diagnose these cases. We see them as a rule before the medical man does. So let's be wide awake and careful to observe lesions that are of a few weeks standing and if we can't treat them refer them to some cancer clinic. Tomorrow afternoon we have a number of lantern slides that I will go over and discuss cases that you have had and that I have had, and if I can be of any service to you at that time it will certainly be a pleasure.

I hope I haven't infringed upon the doctor's time that is to follow me. Thank you. (Much applause.)

President Branch:

Gentlemen, we want to thank Doctor Conner. He is going to be with us through tomorrow and if any of you folks want to ask him any questions I would be glad for you to corner him off, and I am sure he will be glad to answer them for you.

Now Doctor Brown, who was with us today, is going to talk to you at this time on Amalgam Restorations.

Dr. R. K. Brown:

I was very fortunate in having dinner last night with Doctor Lyons, of Richmond, Virginia. He said, "Brown, you will have a good turnout tonight." I was quite flattered. He said, "Not because they are coming to hear your paper, but because there isn't any other place they can go while it is raining." (Laughter.)

I want to try and follow up what I discussed this morning with you.

AMALGAM RESTORATIONS

R. K. Brown, M.S., D.D.S., F.A.C.D.

The adoption of specifications for amalgam by the American Dental Association in 1929 and their modification January 1st, 1934, has resulted in important developments of clinical significance in the manipulation and use of this filling material.

The profession has been more ignorant about amalgam than about any other material used for reparative work in the mouth; consequently, it has been abused more than any other filling material and has, therefore, gained a bad reputation. Careful clinical observations by competent individuals have been lacking, for in the past, operators, teachers, and students have felt that amalgam had to be used, but that it should not be discussed on an equal basis with gold foils or inlays.

The present social and economic status of our people, however, has called the dentists' attention to the possibilities of the amalgam filling, and the metallurgical researches that have been made on this material, with their ensuing clinical application, are providing dentistry with a means of tooth restoration which will render service that will compare favorably with that of any other filling material. The work of Ward on amalgams has been outstanding over a period of years, and the operative staff at Michigan has had the advantage of his help and coöperation in developing an amalgam technic based on the metallurgical findings of his researches with this material. Consequently, because of this interrelation of the research and clinical departments, our technic for amalgam has a firmer scientific foundation than that for any other filling material. Operators realize that amalgam calls for deep cutting of cavities in order to have a sufficient bulk of amalgam to resist the forces of mastication; this factor alone has caused many to look with disfavor on the material.

Dr. D. M. Cattell[1] has stated that seventy-five per cent of all fillings are of amalgam, and he rates the various filling materials according to their value to the patient on a basis of one to one hundred, as follows:

Gold foil	100
Amalgam	90
Gold inlay	70
Porcelain inlay	40
Silicate cement	20
Phosphate cement	10

Thomas W. Humble[2] examined one thousand extracted teeth that had been filled with amalgam and gives the following observations:

87% showed lack of proper cavity preparation.
89% had poor anatomical carvings and contours.
90% were poorly finished at the interproximals, had cervical overhangs, and were not given a final polish.
62% had amalgam that was poorly condensed and adapted in the cavity.
48% had no cement base when it was indicated.

These percentages show the abuse to which amalgam is subjected by our profession, yet all of us would agree with Dr. H. W. Gillett that "if the profession were to be compelled to surrender all but one of its filling materials, the one to be saved should be amalgam."[3]

Amalgam is indicated for use in cavities of deciduous teeth. It is used in the permanent dentition posterior to the distal surface of the first premolars; it is seldom used as a gingival third filling on the labial surface of the premolars or on the buccal surface of first molars. The selection of any filling material, however, depends on the judgment and experience of the operator and on his technical skill.[3] The age, health, and habits of the patient, the environment of the tooth, and the dental health of the tooth and its investing structures all affect our choice of a filling material.

Although the dentist often chooses amalgam as a filling material for economic reasons, because it offers a less costly means of restoration than either the gold foil or gold inlay, it must not be considered cheap filling material. Let us take into consideration both æsthetics and economy, but remember that small Class I cavities and many gingival third cavities in the posterior teeth, as well as many compound cavities, can be successfully handled with this material.

Cavity preparation for this material follows the procedure given by Dr. Black, with a few changes in keeping with developments in the study of amalgam. The box type of cavity is not so destructive of tooth substance in close proximity to the pulp as one might suppose. Wylie and Yant[4] of Western Reserve University compared the popular slice preparation of cavities for the gold inlay with the box type of Class VI cavity preparation in an *upper first premolar*. He found that

(1) 14.79 per cent of tooth substance was lost in the box type of preparation, and 13.31 per cent in the slice,
(2) the cavo-surface margin was 6.71 per cent greater in the slice type than in the box type,
(3) the mesio-axial wall of both cavities lay the same distance from the long axis of the tooth, and that
(4) the disto-axial wall of the slice preparation was 12.84 per cent nearer the long axis of the tooth than the box preparation.

This evidence places the amalgam cavity preparation in a more favorable light than before, although it is admitted that cavities

are being cut with deep occlusal steps and with large dovetails and cervical floors in order to have sufficient material to resist a tendency to flow.

A Class II cavity preparation embodies the principles advocated by Dr. Black for amalgam cavities. The proximal surface is prepared by extending the labial and buccal cavo-surface angles to areas that admit of finishing the filling and allowing the tooth brush to cleanse these margins. The margins are not extended to the axial angles, which are admittedly immune areas but which call for too great a destruction of tooth substance. These walls are cut with cross-cut fissure burs to give parallel dentinal walls, if possible; the enamel walls may flare outward following the plane of the enamel rods in this area.

The gingival floor is placed under the free margin of the gum, although probably Black never intended that cavities should be extended under the free margin of the gum unless caries made it necessary. His text on operative procedures shows all of the gingival margins of his cavities well to the occlusal of the cemento-enamel junction, provided a strong enamel wall could be prepared and the filling properly finished. The enamel margin of this floor is given an outward bevel with gingival marginal trimmers to remove any short enamel rods and to facilitate finishing the filling at this point. Bronner[5] advocates an inward incline of 5°C. on this floor to prevent a rotation of the filling outward when placed under tension.

The occlusal portion of the cavity is most important. This part of the preparation should be cut with the 700 series of cross-cut tapered burs, making an inlay preparation in this part of the cavity. This supplies a deep bevel, removes any short, unsupported enamel rods, and gives as much bulk as possible to resist the direct stresses of the forces of mastication. The dovetail is cut as large as possible, and wide at the angle formed by the pulpal and axial walls. This is a strategic area in which great bulk and strength are needed. Further to strengthen the mass of amalgam at this point the axio-pulpal line angle is beveled.

The last step is to make these walls smooth. Then, with a 35 or 36 inverted cone bur all occlusal walls are undercut where they meet the pulpal floor. This convenient form prevents the amalgam from springing back as it is adapted to the tapered cavity and allows thorough condensation and packing.

Further to resist the flow of amalgam and its tendency to fracture at the isthmus formed by the occlusal and proximal surfaces, the line angles formed by the axio-buccal and axio-lingual walls are grooved with a 56 or 57 plain fissure bur, cutting rather deep into the buccal and lingual at the cervical and tapering out at the axio-pulpal line angle. These grooves are not sharpened with angle-forming instruments as amalgam could not be condensed as efficiently in sharp angles. These are aids to both resistance and retention forms. The resulting cavity is really a combination inlay and fail cavity preparation, except that it is cut to give more bulk to our filling material, which is essential to its longevity.

Avoid placing a margin so that the opposing cusp of a tooth will come directly in it. Any cavity walls or cusps that are protected must be cut down to give a very large bulk of amalgam when restored to normal contour; otherwise, the restoration will fail at this point.

The amalgam inlay, an amalgam filling that is inserted into a cavity partially filled with soft cement, is used by many of our most successful operators. Pond[3] of Rutland, Vermont, and Tison[6] of Gainesville, Florida, have described their technics in detail, as follows: the cavity is outlined with enamel rods resting on sound dentin; decay is removed and, if the pulp is in close proximity to the cavity, a protection is used covered with a cement base. The cavity is not built up, however, as it is for a gold inlay or foil.

A mix of cement, similar to that used in the setting of an inlay, is inserted in the cavity. Crown and bridge or slow setting cement may be used, for they set rather slowly and give ample time to work. The cement is removed from the cavo-surface margins, especially those of the buccal and lingual proximal walls and the cervical floor. The amalgam is condensed into the cement starting at the cervical floor and its external margin, and is worked in an orderly manner into the cement-lined cavity toward the pulpal region. As the filling progresses and as cement is extruded toward the margins care should be taken to trim it with excavators or chisels so that a cement line does not result.

The amalgam inlay gives a large bulk of filling material, which is essential with amalgam, and has the advantage of having a cement lining. In this respect the amalgam inlay is on a par with the gold inlay which has obtained much of its preëminence from the use of a cement intermediary.

When Humble stated that 48 per cent of amalgam fillings had no cement base, I feel that he gave dentists the benefit of the doubt. After removing amalgam fillings from teeth for over fifteen years in my practice, and after removing or overseeing the removal of hundreds of fillings in an operative clinic over this period of time, I would say that at least 75 per cent of our amalgam fillings lack a cement base or lining when it is indicated. Judging from the close proximity in which amalgam is placed in relation to the pulp, it would seem that the profession looks upon it as a pulp protector or capping material. This is a most serious abuse of the material and has caused many pulps to degenerate with varying degrees of rapidity. Cavities that have undercuts should have cement basing and, if the pulp is approached, the cavity should be phenolized and a protection such as Kerr's Sealer or a similar preparation should be used. If necessary, the use of a reduction of silver nitrate may be advisable, before the pulp protection is used.

Cavity liners are essential in all operative procedures which involve the cutting of dentin, whether it be for foil, inlay, silicate, porcelain or amalgam work; they are indicated before cement bases are used to seal the tubules against the ingress of acids; they are essential when silicate fillings are made; and they are particularly appropriate to line an amalgam cavity if the amalgam inlay technic is followed.

Dr. Rickert, Mr. Zimmerman, and I have been studying eight popular commercial cavity liners and have found that the synthetic resins are far superior to those of the cellulose derivatives. Acids have a marked deteriorating effect on these liners and a cement mix applied to a cavity lined with this material would cause destruction of the cellulose film, making the liner worthless. We feel that at present there is only one liner that approaches satisfaction and this one could be greatly improved.

When the cavity preparation incident to the making of an amalgam filling has been completed and the cavity lined and cement based, if indicated, an alloy is selected that meets the modified A. D. A. Specification No. 1, and a mercury that passes the A. D. A. specifications. This mercury will also pass the U. S. P. requirements, but the terms "chemically pure" (C.P.), "technically pure" (T.P.), redistilled, or triple-distilled mercury have little significance to the dentist. The filling must make a tight plug, must have a desirable volume change, and must possess sufficient strength, though not the greatest possible strength, to resist the forces of mastication, according to Ward.[7] The manufacturer of the alloy should give clear and concise directions for the use of his product, emphasizing the following:

(1) Proportions of alloy and mercury to be used (5:8);
(2) Type of mortar and pestle to use, smooth or rough, viz., sand-blasted or etched;
(3) Statement whether the alloy and mercury are to be stirred or ground during mixing;
(4) Mixing time in mortar and pestle, giving grasp of pestle in hand and the number of revolutions per minute of the pestle in the mortar (pen grasp—220 to 240 r.p.m.);
(5) The number of hand mulls, giving the speed for one minute (120 to 130 per minute);
(6) When and how excess mercury is to be expressed;
(7) Method of packing alloy into the cavity.

These directions when followed should give a normal mix of amalgam having the following:

(1) Mercury teased to the center of the alloy;
(2) Mercury placed in solution or in contact with all particles of the alloy;
(3) No discernible crepitus during hand mulling;
(4) A mass which will take finger prints, roll into a rope without breaking, and give a smooth-grained, plastic mass, with no evidence of crepitus.

The choice of a matrix retainer in compound cavities is important; with Class II cavities use Harper's new matrix holder or Ivory No. 1 matrix retainer. The Perry separators and the Dickinson matrix retainer can be used to good advantage. For Class VI cavities use the Wagner or Ivory No. 8 matrix retainer. If a protected cusp

restoration is to be made, use a copper band that is contoured and fitted for the case in hand. The band is cut so that the occlusion is cleared; then elliptical holes are cut on the proximal surfaces of the band so that contact points are secured. It is essential that the contacts are properly placed and that they are of sufficient size. The contact points are countersunk from the inner surface of the band to prevent the formation of a shoulder with the thickness of the copper band. This band will remain in position for twenty-four hours after the filling is completed.

The matrix is fitted carefully to the cervical and held in place by toothpicks, cotton, or some other material that will confine the band to its proper position. Some ligate the copper band, but this has not proved satisfactory in our hands.

Packing and condensing the amalgam into the cavity is important and deserves detailed description. Take the triturated mass of amalgam, break a piece from it, and place balance of the mass on the bracket table until it is needed. Start the filling at the cervical or pulpal floor depending on the class of the cavity. Place the mass in position with a Black's No. 2 or No. 3 plugger, tamp it gently from the center in sweeping circles to the outer surfaces, spread it well over the floor into basal angles, and work excess mercury to the surface. Work the soft-surface amalgam up along the side walls, using a packing pressure of eight to ten pounds throughout the procedure. Apply a Black's No. 1 or No. 2 plugger to the center of the filling and work gradually outward in an expanding spiral with either a continuous burnishing motion (Harper) or an orderly stepping of the plugger, advancing it one-half its diameter as it progresses.

Increase the pressure considerably and, when the walls of the cavity are reached, bring pressure to bear on the mass both toward the walls and parallel to them, extruding the soft amalgam upwards and condensing firmly the remaining amalgam into an intimate nonleaking adaptation. Continue this orderly condensation several times if necessary, until only a slight depression can be made with a small plugger (Black's No. 1) when firmly pressed into the filling at this stage. The cavity walls are stepped with Black's No. 1, No. 4, or No. 5 plugger, advancing the plugger one-half its diameter at each step. This obtains marginal adaptation.

Use the next portion of the alloy in the same way, tamping, condensing, or burnishing it, and working toward and up the side walls, until every microscopic irregularity and basal angle is well filled.

Make each succeeding portion of amalgam drier than its predecessor by squeezing out the excess mercury with thumb and forefinger, then placing it in the cavity, build the filling well above the margins, which are finished smooth and sharp and without bevels, for tight joints at the cavo-surface angle prevent recurrent caries.

Tap the filling with repeated light blows from a fairly heavy, smooth-faced instrument, such as the distal surface (not serrated face) of a No. 7 Crandall condenser and a fail mallet. This drives

the dry granules of the surface mass of amalgam deep into the filling, forcing out the excess mercury. The Harper mercury expresser is also useful for this purpose. Remove this excess of mercury and repeat the tapping until no more mercury can be driven out and until each blow gives a sharp metallic ring, showing that the amalgam is well condensed into a rigid body. It is now hard to indent the filling's surface when a small plugger face is pressed into it.

The filling should be carved and contoured. Keep the matrix in position for from three to five minutes after the amalgam has been condensed; check the occlusal portion of the matrix band to be sure that no amalgam covers it so that the band may be removed without fracturing the filling. Carve the occlusal to anatomical form, using as a guide the same tooth in the opposite portion of the jaw. Use the Diack or the Frahm amalgam carvers and check the carving with the occlusion and articulation of the patient to obtain as perfect a carving as possible, using articulating paper carefully to guard against fracture of the filling.

Burnish the carved surface until it is bright and mirror-like. Wipe the surface with cotton and if it dulls, reburnish and wipe it again, until the lustre remains permanently. Remove the matrix and finish the approximal surfaces and margins to correct contour with either the Gregg or Darby plastic trimmers. The Rhein files are useful to improve proximal contours and any possible cervical overhang. No amalgam should have a cervical overhang for it can be removed while it is plastic.

The cavity must be kept dry, for if saliva dries on cavity walls, it leaves soluble salts that are dissolved by fluids of the mouth after the filling is placed, and leaky margins will result. Dr. N. O. Taylor[9] claims that contact of amalgam with saliva during the filling operation decreases crushing strength twenty per cent in the final filling. Precautions should be taken to maintain a dry field and, if necessary, a rubber dam should be used.

Allow the filling to set for from twenty-four to forty-eight hours or longer. When the patient returns, polish the margins with Moore's discs, medium emery, medium cuttle fish, and crocus, used in the order named, until a high lustre is obtained. Polish the anatomy with stones and plug finishing burs, paper discs, and then Burlew polishing discs of the wheel, cone, and sulci shapes.

Apply flour of pumice with bristle brushes and then tin oxide until the occlusal and all proximal margins are given a mirror finish, the interproximal being polished with strips charged with pumice and tin oxide. A fine polish makes a great appeal to the patient, prevents recurrent decay, and gives a feeling of satisfaction to the operator.

When the patient returns at regular intervals in the future for oral examination and prophylaxis, it is sometimes necessary to regrind and repolish the margins and surfaces of the filling; this will lengthen the life of the filling and often remove discolorations.

The profession has regarded amalgam as a cheap filling material and has handled it in a careless way. If we follow a careful technic

and use acceptable materials, the filling will be very successful and can and should be used, as Dr. Blackwell[8] has stated, in far more proximal cavities in posterior teeth than it has been used in the past. The present economic situation is causing many dentists to brush up their amalgam technic, and see what they are really able to accomplish with this material.

The amalgam filling that has been carefully executed will repay both the operator and the patient for careful attention to detail. Amalgams have a distinct place in operative procedures and they will fill it with honor if given a fighting chance.

As metallurgical researches are being conducted and as clinical observations are being made, it may be seen that this material has great possibilities and it is hoped that the coöperation of these two units will continue and that much good will result. In conclusion I should like to make one final statement: the manufacturer makes the alloy, but the dentist makes the amalgam. (Much applause.)

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President Branch:

I wish to again thank Doctor Brown for bringing us this message tonight, and as I said just now in regard to Doctor Conner, Doctor Brown will be with us through tomorrow and you will have an opportunity to talk with him now and tomorrow in the clinic, and you will have the opportunity of asking him all the questions you want.

The meeting is now adjourned.

SECOND DAY—TUESDAY, JUNE 19, 1934

Morning Session

The meeting was called to order by President Branch at 9:00 o'clock a.m.

President Branch:

Gentlemen, the convention will come to order. We are fortunate in having with us this morning one of our good friends from the State of Virginia, whom we presented to you yesterday afternoon, who is interested in the same things we are interested in in this State and he is really one of us. And we are going to ask Dr. Tally Beleau to introduce the speaker. Doctor Beleau.

Dr. Tally Beleau:

Mr. President, members of the North Carolina Dental Society: It is kind of an unexpected pleasure for Doctor Branch to ask me this morning to introduce the first speaker.

For the last six or eight years, I have been rather intimately associated with a man who has been an inspiration to me in my work. Here is a man who has combined the thrift of his Scotch ancestors with his American idea of service to work up one of the best practices in children's dentistry of any man in this country. I have heard Doctor McBryde on several occasions and each time I think he improves. He has held clinics and appeared as an essayist from the Atlantic to the Pacific and from Canada almost to Mexico. He gives of his time freely to pass on the knowledge and information he has.

And I consider it a real pleasure indeed to introduce to you one of America's leaders in his field, Walter C. McBryde, of Detroit, Michigan. (Applause.)

Dr. Walter C. McBryde:

Mr. President, Doctor Beleau, members of the North Carolina Dental Society: That is a rather flowery introduction. I can't help but think of the Scotch widow who was sitting in the Presbyterian church one beautiful sunshiny Sunday afternoon at the services of the departed husband. He hadn't been a particularly fine husband to her; he had been careless; he hadn't maintained her very well; he was shiftless; his habits weren't the best—and she knew this well. But the minister, who was new in the parish was eulogizing at great length the fine merits of the deceased; he told what a fine

husband he had been and what a splendid provider and what a fine father he had been. The widow was sitting there listening with a great deal of concern, because she knew it wasn't true. And as soon as she could, she turned to her daughter, Mary, and said, "Mary, is there another corpse in the room; I don't recognize your father." (Laughter.)

So Tally has gotten a little wrong in his very fine and flowery introduction; however, I rather like it. I like the charming manner of you Southerners.

I am amazed at the group that gathers this morning after the big day you had yesterday and the big evening you had last evening. Folks were having a good time last evening and I am surprised to find you out here this morning, but there is some impelling force to dentistry that seems to draw them back to a dental meeting—I don't know what it is—it is something like the returning home of the wanderer.

Now the subject assigned to me this morning is "The Business Phase of Dentistry for Children." I don't suppose I have anything new to offer at all; in fact, there isn't much new. Something like the boy sitting by the light of the kerosene lamp doing his arithmetic. And his father was sitting also by the lamp reading his paper. And the boy would shift from one side to the other and then he would squirm, and from that he would lean on one elbow and then on the other, twisting his hair, pulling and twisting his pencil, twisting his ears. And finally the father said, "For the Lord's sake, John, what in the world is the matter?" And John said, "Dad, I am doing my arithmetic." And the father said, "Well, what is bothering you so much?" And the boy said, "I am trying to find the least common denominator." The father said, "For goodness sake, are they still looking for that? Why, they were looking for that when I was a boy." (Laughter.) So what I have to offer isn't very new, but I will try to dress it up in a new gown and attempt to fix the old girl up so she will look a little bit more attractive.

The business phase of one's practice isn't very attractive and I have said so many times to my assistant. If it just weren't for these things I would enjoy dentistry more. Folks who come in wrangling over little things, rather wear you out. A patient with a family of three children will come in in January, just before they go to Florida for the winter and the bill for the children will be eleven dollars. The father calls me up in May and asks me something about the children, the mother has written and wants to know so and so, and he will say, "I am sorry, Doctor, that the bill hasn't been paid, but you know it costs a lot to have your wife and children down in Florida." A bill, if you please, that was made in January, about a year after due date for eleven dollars, because it was costly to keep the wife and children in Florida! It is those little things that irritate the life and soul out of me and make me think I would like to have a compensating monthly paying job.

However, I enjoy my work immensely but these things irritate me and I guess you know most.

There are four things to do with children's dentistry which I think prove to be bug-bears to the average person in practicing for

children. I think I know the emotions of the average dentist when he thinks of children. I think he has in mind, "Well, children would not be so bad if they behaved better." And then you think, "If my fillings didn't come out, it wouldn't be so bad." Then you think again, "If I didn't have so many devitilizations and costly restorations, it wouldn't be so bad." And then finally you think, "Darn it all, if I could only get paid for it, it wouldn't be so bad." Those four things I think are the undoing of children's dentistry. Now this afternoon we are going to talk about some of the other phases but this morning we will discuss the business phase, the question of getting paid for it, the fee question. The fee question is a mighty important thing; it is well worthy of discussion. A great many dentists have worked out the plan of charging on a yearly basis for children. I don't know whether it works or not, I haven't tried it. I have attempted to but in my city we have a man who tried that out; and every patient that comes to me from that office—and there are always patients of mine going there and occasionally a patient comes to me—and every patient that has come from that office has come because of the inadequacy, so to speak, of that yearly payment. The patient has to go every month to his office and they pay a yearly fee, regardless of what is done. It might work out well, I think, if you saw the patient less regularly and kept the patient longer and it would save a lot of running for the patient and in a big city that means a lot. But in my own practice I have always charged on a fee per hour basis. On the operating basis you get hot in the collar about what to charge. You know what it ought to be, you don't know what you feel free to charge. On an hourly basis it equalizes the cost of the fee, and it doesn't seem to bother the parent as time goes along. It will give you a lot of comfort, too, with the child patient. Many times you see a patient today and you do quite a bit of service for him but there is nothing tangible that you can present to the parent; you can't say, "I put in so many fillings or extracted so many teeth," yet at the same time you have done quite a little service by treatment or preparation of the tooth to be filled. The fee per hour basis will equalize this. It may seem less today and more tomorrow but when all is through, it is very much equalized. Parents ask me over the telephone and at the office, "How much do you charge for fillings?" Just before I get to that, I would like to mention a word about the estimate.

I know I use a lot of the first person here; I expect to all the time; I was asked down here to tell you what I do, not because it might be the best way, but just what I do. If you like it, fine; if you get anything from it, fine, if you don't, you will have just wasted an hour with me here this morning. So I will speak in the first person most of the time.

And I do give an estimate when the patients come in. I know that parents want to know what the cost is going to be, but some don't like to ask, and I relieve them the burden of asking and I say, "Would you like to know something about what this will cost?" And you can always see the smile on the mother's face that she don't have to ask you, that you are willing to tell her. And it gets me out of a lot of trouble later on and I can say, "That will be so much,"

or "Approximately so much." And immediately comes back the inquiry, "Well, Doctor, how much do you charge per filling?" I have already shown the mother what is to be done. I think that is a very fine thing to do, to show the parent just what needs to be done, and then tell them what the cost will be. They will immediately try to figure out in their own mind how many fillings there are and how much the total cost will be and if they don't figure it out, they will say, "Well, Doctor, how much do you charge per filling?" And I have worn thread bare in the office the remark, "I have no fee per filling; the charges depend upon the size of the cavity and the response of the child." Now, parents aren't dumb and they can figure out immediately two things, the very things you would like them to understand, and that is "If I come regularly, the cavities will not be large, therefore, the cost will be less" and "If my boy behaves better, the cost will be less." Anything that strikes home to the family pocketbook is a very important point and I think it does. And so I have no charge per filling but it is dependent upon the size of the cavity and the response of the child. The parent will come back and say, "Do you charge by the hour?" And that is rather a difficult thing to answer, but that inquiry will nearly always come. If you tell them you do, they will immediately ask, "Well, how much per hour?" And you just can't tell that, because the average person coming into your office has no regard or concern for overhead. He has a job and gets paid forty or fifty dollars a week and on Saturday night he has forty or fifty dollars in his pocket; there is no overhead. And they can hardly visualize the fact that perhaps forty per cent of what you take in goes for overhead. People can't visualize that. And so I don't tell them flatly what I charge per hour. If I can't put them off by saying that I look in the mouth and sort of estimate the number of visits that will be required and the length of the sittings in a rather vague way, then I don't hear very well, and I don't answer the inquiry. In the end it is the same to them. I am not fooling anybody but it seems large to them. It isn't large at all, it's more lenient than if charged for on a basis of so many fillings and you are just protecting yourself against things that irritate people. And so I try not to irritate them with that point.

Another thing I think is about the most abominable feature in my practice and that is to let a person pay as they go. I have reference to the very business like father or mother who comes into your office and has some work done and immediately steps up and says, "I always pay as I go; now how much will that be this morning?" I know what human nature is like. If I have in mind that the estimate of this work will be say eighteen dollars, but I have given no estimate because this parent is very business like, and if I tell her, "That will be four dollars," she will think, "Isn't that a little bit high?" And the next day she comes in and it is maybe four dollars again or five dollars and she again thinks that is high. People carry very little money these days and she will probably want to shop a little on the way home, and she will feel stripped when she leaves my office. And the next day she comes back and it is three or four or five dollars again, and each time that parent

leaves my office she thinks it is a little high price. Now, I can give that same parent an estimate of eighteen dollars or tell her that the work when all completed will be eighteen dollars and she will pay it without a flicker of an eyelash, and if she does think it is a high price, at least there is only one shock, and that is something. I can send you men down town, anyone of you here, today with ten dollars in your pocket and if your car breaks down and it costs you four dollars and fifty cents to fix it, you aren't very much concerned because you still have five dollars and a half left in your pocket; but, if your car breaks down and you have only five dollars in your pocket and the garage bill is four-fifty to fix it, you haven't but fifty cents left and instinctively you will call the mechanic a robber. It is simply a matter of perspective. And for that reason I don't want patients to pay in my office. When the very efficient and business-like mother gets up and says, "How much will that be today? I always pay as I go"; I tell her that I will give her credit on the entire bill for the work; in other words, I say "The whole bill will be so much, Mrs. Brown, and you can leave as much as you like." So I let my patients know what the total cost is instead of paying as they go. It saves a lot of grief to me.

Just suppose you would like to try out a scheme of this kind; suppose you would like to utilize your spare time, and by spare time I mean actual school hours. I understand that in the average practice there is a lull there between four to six when it is too late for mothers and too early for the fathers because the men can't leave their business. I don't know, but I have been told that that is a good time to get the children out of school instead of waiting until Saturday. But, first of all, you would have to decide how much you should charge per hour. I don't know what one should charge per hour here or there; things are vastly different in the world. I know how they are in my office, but I don't know how much you feel that you ought to have per hour. But suppose you were going to try it out anyway, you would have to determine some way or other how much you should have. And just suppose that we utilize four or five dollars. Now that isn't enough, but let's utilize the four dollars. If that isn't enough, you can just multiply it by any amount you want to. Let's take a patient in at four o'clock, say after school, to try this just for a week. Here is a patient that has come to your office regularly, and you have placed in the parent's mind the idea of returning periodically because it costs less and the pain is less and the fillings last longer. The patient comes today and you do some prophylaxis and possibly you have one small cavity, or suppose you just have one small cavity and you put it in in a few minutes and you have given the patient a half an hour appointment, you can do that in a few minutes and you have those two dollars to your credit. Then, you may have a 4:30 patient and perhaps this child has a whole mouth full of bad teeth, his teeth all broken and ragged, so to speak, if you concentrate on one or two fillings today and do them well, you will do yourself a favor and do the child a fine service. Very frequently when a dentist attempts to do too much in one appointment the patient will not come back for the second appointment; and, if you try to do it in too big a hurry perhaps

the fillings are not properly anchored and you will later hear from the patient about it. But if you will prepare for those fillings you can do those too, if you work diligently, in half an hour and you know that the fee to the parent is very lenient, and yet you are being paid the exact amount that you want for your service, two dollars. Now comes the 4:30 patient and she has a number of those little incipient caries just here and there, not big ones at all. They can be put in in a very short time. If you do this for two dollars you drive home to the parent the very fact that you are trying to get across, that you have no charge per filling. Many times I will do three or four fillings for three and four dollars and many times charge three and four dollars for one. Now the five o'clock patient comes in and you only have prophylaxis and you can do that in half an hour. You can see that that will figure forty dollars for the week and one hundred and sixty for the month. You can see that, if you can add right or multiply right; but you will say again that it isn't feasible.

That is feasible; for twelve years I have earned my income strictly and entirely on that basis. I have no fee per operation; and I have a lot of comfort as I go along. I don't sit and watch the clock either, for many times I don't know when the patients come into the office or when they leave. And my income has been figured entirely on that basis and it is just as feasible as can be and just as practical as can be, and it gives you a lot of comfort in the long run.

Along with this is a rather splendid contribution from a dentist who worked for an institution, and this group of children numbered one hundred and ten and this was over a six-and-a-half-year period, and he learned over this period that the average cost per child per year at seven dollars per hour at this institution—and this was in the golden years, if you please—the institution paid him seven dollars per hour for his time, and at seven dollars per hour, the average cost per child per year was eleven dollars and forty cents. Just laugh that off! That is a very lenient fee and I think if you could sell your parents on the fact that it costs approximately twelve dollars a year to maintain a child's mouth, that there would not be nearly as many extractions as we have. I know there are large families where that can't be done, but in the average smaller family that comes to you for service that is a very fine fact to throw out, especially to the mother that lets the mouth become completely wrecked before they come; then you have a number of large cavities that require much punishment and the bill will be around fifteen or twenty dollars for the first service or appointment. You can say, "It would mean a lot to you if you will pay me twelve dollars a year and I will keep this mouth in good shape, anything the child needs, and there will not be a series of extractions and tooth ache." It is quite a fine selling point with you.

Back in the golden days of 1929, when folks were playing the stock market heavily and then the crash came, the fellow who was making the most money and had the most work was the fellow who cried the most. And I used to hear my associates in the building go around saying when you asked them how business was, "Oh,

not so good, terrible, a few fillings and prophylaxis, but nothing big." And it was rather amusing to one who was doing pedodontia with this little stuff. And it would be a little disconcerting to a fellow sometimes, as if to say, "All you need is a tin cup and monkey and you could start out." They would look down on the fellow who practiced children's dentistry. For years and years I have had to listen to such remarks as "Well, Mac, are you still fooling with the kids?" And yet I could take those same men in my office any day in the week and show them less playing around with the kids than you do with your adults. Just how many times have you stood with your foot on the control and your mirror in your hand, just waiting for Mrs. Brown or Mr. Jones to finish a long harangue about some uninteresting thought, and the time was going on and you were so interested in getting this work done because you had another patient waiting. Now you have had to stand for that a countless number of times. With children, I can sit them down after the initial appointment which takes just a few minutes, and if they want to talk, I just open his mouth and away we go. I have to be courteous, it is true, but children don't require that of you. And I will wager with any of you fellows that I have less fooling around with the kids than any of you do with the adults. I make it a business proposition in my office; I have no toys to play with; I have no songs to sing to them; no stories to tell. To me it is a business proposition; I am there for two things, to do the dentistry and to earn an income for myself. And don't think of pedodontia as just fooling around with the kids. But they used to make those remarks and I guess it was said particularly to one who was caring for children.

I thought I would see where my business was coming from and so for the year of 1930, I kept a chart of all the work I did, and to me it is rather a fascinating thing. I divided my work and each day I made a record of the work I did. Now, when the year was finished, I found that prophylaxis gave me twenty-three per cent of my work. As to prophylaxis, I have heard many say, "I can't be bothered with prophylaxis." But it is a very consoling thing to me in practice where we use the periodic return to know that during June, July, August, and September, whether school keeps or not, I am going to have a week's work in that month, a little more guarantee than you have, perhaps. But I know that is going to happen because it has been happening for twelve years. In other words, I have in this period on the ticket extra work always ahead of me, one month's work, four weeks, three times a year. It is a consoling fact and something that costs very little.

Now, the matter of fillings, forty-nine per cent. You will expect naturally that that would cost very little in my practice. That is the major thing I do. I have gold inlays—and I mention this just to show you that I have a very small percentage of work attributable to that. I am quite content with using a very serviceable amalgam filling; in other words, I would rather put in an amalgam filling that was well done in a young child with a six-year molar that is sensitive than to put in an inlay for which the preparation was very poorly done; and many of these children at six or seven with

new teeth, it is very difficult to perform the kind of preparation that you would like. So I utilize in my practice mostly amalgam; however, there are instances where the other works out well. Gold inlays figure 2.5 per cent.

Now extractions, local extractions, are 2.4 per cent. This is a very small portion of one's practice. I use ethel chloride a great deal and general anæsthetics. But I utilize it in children's practice, for this reason, that regardless of how fine a hold the anæsthetic may get, a child always remembers the mental pain of the extraction, and no matter how fine your anæsthetic may be, you can never eliminate that with local anæsthesia. I am not asking you to change your way of work, if you please; I merely bring that point out. Where I have been forced to, under protest, I have used novocaine. But when the average child thinks of dentistry and extractions, he thinks not of the fact that it didn't hurt, but he thinks of the terrific emotions that came when the tooth came out. So I use ethel chloride and gas a lot. My gas extractions run ten per cent of my practice now.

I have an X-ray machine which I use mostly for my own diagnosing, and I use it a lot. I think the average patient thinks when they see the X-ray being moved out from the wall, "That will cost me three or five dollars." And many times you will not use that X-ray machine because of that emotion flickering through the patient's mind. I have that rather sold in my practice on the hourly basis. I say to the parent, "I have no extra charge for the X-rays"; and I haven't, because on an hourly basis I am going to use practically ten minutes time talking about this X-ray and about taking it before having it developed and maybe discussing it a little bit again, and so I have used one-sixth of an hour in this X-ray operation and one-sixth of the hour is gone and it is figured in on the hourly basis. So that the patient does not feel that they have paid an added fee for that and yet I have received sufficient compensation for the average X-ray. On an hourly basis, that thing works out very nicely.

I have listed here treatments, 5 per cent. Six per cent is for miscellaneous. And then the matter of broken or canceled appointments, 1.2 per cent.

Now sometimes when Mrs. Brown fails to come down for an appointment, it is rather disconcerting as you were expecting to earn that money and it is easy to charge it but it is another thing to collect it. In my own practice I know on the present basis of things that my average overhead per operative appointment hour is $1.39, for every appointment I make, as I make forty-five-minute appointments. I take ten children a day, sometimes eleven, with forty-five-minute appointments and I know for each appointment hour I have to earn $1.39 first, which is an average overhead of about 41 per cent. I know that I have got to go ahead and earn that and if an appointment is broken, instead of charging what I expected to earn, I can keep better in the grace of the parent by charging a fee of two dollars for a broken appointment. And when the parent calls and requests a bill at the end of the month, which they always do, I have the opportunity to either collect the two

dollars or to get the parent in a frame of mind that they will not do it again; and in either case it is worth two dollars to me. If the parent sees the point, she will call at the last moment and say, "I just can't come, I guess I will just have to pay you your charges." But even if she complains about the bill it is worth two dollars to me, because I can say to the parent "It isn't the fact that you failed to come that bothers me most of all, but you deprive me of the privilege of earning three or four dollars from some one else." It is the deprivation of that earning power that irritates me. I know full well the parent will not do that again, and it is worth two dollars to educate her. Whether I collect it or not I am getting it in. Where, if I should charge three or four or five dollars I know I wouldn't get it and I would drive the parent forever from my office.

I believe that one can well utilize a few practical suggestions. At least I calculate or figure on them some in my office; and you know, by this 23 per cent prophylaxis I work for the business of getting patients back. These children who are in school during June receive a note in October that it is time to return for a periodic examination in prophylaxis. When the children get to be twelve years of age or older or when the second dentation has arrived, I push them up to a six months schedule, but I have very few children past twelve years of age. It is very peculiar in my practice that I have never dismissed a patient. A boy will say when he gets to be twelve "I won't go back to the kids dance any more" and so he just doesn't go back. Pride gets hold of the girls just a little bit later and so she stays on with me until she is fifteen and then just fails to come back. I suppose we have twenty-five or thirty girls over fifteen years of age and that certainly has been a help.

But these prophylaxis notices I send out for a return for prophylaxis, I use an acknowledgment card. You may say, "Well, that is no value in a practice." But, gentlemen, it is. I think I get more value from my acknowledgment cards, going to laymen, than I do to dentists. It is customary to one who confines his work to a definite phase of dentistry to send notices, for instance to Dr. Brown "We were pleased to have Mr. Jones for treatment," something of that kind. On the other hand if Mrs. Brown sends a patient she is very much pleased to receive a note that Mrs. Smith came for treatment. You can bank on Mrs. Brown scouring the neighborhood to find you a new patient when she thinks you have taken the time out of your busy practice to sit down and write her a thank-you note, so to speak. And I never fail to send an acknowledgment card to any layman who sends me a patient. I think it helps more to maintain and carry on my practice than it does if it goes to the dentists. It is a perfunctory salutation as far as he is concerned.

Because we have had trouble getting children from school, I have an excuse card, perhaps the only original thing I have ever had in my practice. Mr. Cody, superintendent of schools, tells us that children are only to be excused for medical or dental attention at any time without being marked absent. The teachers will back up on this considerably, the teacher will refuse sometimes to let the children out, and in the private schools it is almost impossible to get

them out. But in the public schools the teacher will refuse sometimes to let them out because they have been excused before under the guise of going to the dentist or the physician when they will go to the movies or to see their Aunt Mary or somewhere else. The teachers know that and refuse to let the children out. So I have an excuse card for the parent. And I always give them one to take back to school. It says that John Smith was at my office for dental work, Tuesday, June 16, please excuse his absence from school. That convinces the teacher that the child has actually been to my office, which is a fine fact. And it will help me get that patient out of school another day, and secondly it carries my name before the educational faculty of the school, which is also a very fine and ethical medium. And I see to it that every child that comes to the office during school hours gets an excuse to take back to his teacher. Now that is just as ethical as can be and it certainly serves the purpose that I have in mind that I want the child excused, and I can get him out again.

To avoid the confusion of appointments I take my regular business card and turn it over and make the appointment card out on it; now that is nothing new, I just simply say to you that we are trotting out the old things and some of the new that I have. But that helps a lot in keeping patients from coming occasionally on the wrong day and at the wrong hour. I have two places on which I keep a list of all the children who come to me. I list the parent's name and the children's names. And so many times when patients call up they will say "This is Mrs. Brown, I want to make an appointment for the children," and you can't remember all of them; so we keep a little black book on my desk in which we have listed all the children, Alice, Bettie, Kathrine, and we can turn to that and then say to the parent "Do you want that appointment for Mary, Martha, or Fred?" Now you just can't remember those children's names, but it is a splendid reaction you get from the other end of the wire when the parent thinks that you remember the children's names. I am not trying to fool them or fool anybody, but you simply can't imagine the reaction you get from just a little thing like that. It doesn't cost anything, yet it helps.

I am working at my business every day and I am trying to make it a success. And along with that I keep a great many new cases on my cards that will help me at the succeeding appointment. I believe that there is incident to every dental appointment, every appointment hour, something of the business, something professional, and something social. And so I mark on my cards many notations which I call memory chasers, so to speak. I have no special place for them, they just go on the card on which I list such things as these. Now these are of a professional nature. If I say to Mrs. Brown, "Your boy needs such and such a thing done" and refer her to so and so and the patient returns four months later and I say the same thing again, having nothing to remind me, she will say "Well, you told me that the last time I was here." But, if you can turn to her and say "Well, how is John getting along these days?" I have done Mrs. Brown a real service she thinks, and I

have gotten Mrs. Brown to feel that I am rather interested in her boy and that I know what is happening.

On the other card I have "Suggested that the child needs a spacer, but the parent seemed uninterested." I can just pass that by and forget it. In other words it is something she really doesn't want. So when the child returns on another day and I can see two places that need attention, the parent isn't so particularly flabbergasted because I have given an idea of this impending condition and you can go ahead and tell it and the story is not quite so severe. Here is a case where I have advised extraction of the tooth but the parent wants it retreated, so I treated it. Perhaps I wasn't very sure about the tooth. If the tooth goes wrong I have an alibi when the patient comes back for an advised extraction.

Now those are just little things that help me tremendously, I think. In running over a bunch of cards I find these things: "The appointment canceled at the appointment time. Child didn't want to come, the mother said." Now that wasn't my fault particularly and so I charged the average office call charge of two dollars. Here is a broken appointment of one hour, and I happen to know that it is Armistice Day, and I wrote it down, and I guess that is where the boy was or the children. "Canceled appointment on account of an accident." That can't be helped and I couldn't afford to charge for that. Here is one which reads, "Canceled appointment one hour before time. Mother said the child had a school test, but the boy came next appointment and when asked about the test he said: 'No, I didn't have any test, I went to the movies.'" Those things are all helpful when it comes to settling up time, when it comes to the payment of the bill. I have a boy here going to his grandfather's farm for the summer; here is a boy going to camp; here is one, the new baby is named Frances; here is one, family moved into new house, and so on through the list. They don't mean very much to you, but it's mighty interesting to a parent when you say, "Well, how is John" when you haven't seen him in four or five months and goodness knows you can't remember his name. But when you remember the new baby brother or the new house, or something like that, it seems to them that you have an interest outside of the dentistry in the family. In the smaller villages and in the smaller cities you know all of those things, but in cities of our size you just can't know them or just can't remember all of them.

There has been two things incident to children's dentistry that have been very satisfying to me and things that I did not know were there when I went into it. The first is the constancy of the work and the second is the constancy of the collections. If you please, I am not bragging; but one has to make reference to that in order to drive home the thought or the point I have in mind. But I am not bragging when I say that children's dentistry gives a constancy in work and a constancy of collections. The constancy of the work comes through the fact that parents will care for the children's needs first. I have no idea of letting the amount get large. I have no large amounts. The average bill that I render in most cases is somewhere between eight and eleven dollars. In other words I have many times divided the amount of my statements by the

number of children in the home and found it averaged, that the average fluctuation in most cases was between eight and eleven dollars. That is a very lenient fee. Those are small bills, and when the average parent, like the average dentist, starts looking over his bills on the tenth of the month the small ones are always paid first, and my bill usually comes in. Associated with me is a man who sends out bills many times the size of mine and many times I have seen his bills go out for ninety or a hundred dollars and mine go out for maybe three and a half or five or seven dollars, and perhaps his has been standing for four or six months, mine a new bill this month, and along comes my check within the tenth of the month period and he maybe gets five dollars on account on his. That has happened time and time again. Bills do not linger so long with the children's practitioner, and that counts somewhat for the constancy of collections.

I am somewhat of an enthusiastist, as you may have noticed, but I am at least honest about it and I have tried to not let the pendulum swing too far. Elbert Hubbard says that enthusiasm is like a lubricant, the proper amount facilitates smooth working and too much gums up the works; and I try to strike at a happy balance. I hope you may appreciate that from the things I have said.

I have wandered along here for about an hour but I will feel repaid if you appreciate the things I have in mind. I am a stranger in your midst; I wonder if your emotions are something like the story of the two brothers: One a very secular, worldly type who lived in Chicago, and he had no use for the fine things in life, he was rather wayward and indifferent. He knew little about religion. His other brother lived in Denver, a very pious man who lived well, a minister, who kept his father in his old age. One day he wired to his wayward brother in Chicago this message: "Jesus came last night and took father away." Either the boy in Chicago didn't appreciate who Jesus was or else there was an error in transcribing from the telegram to the code; any way he wired back this inquiry, "Just who is this Jeeie and where did she take the old man?" (Laughter.) (Applause.)

President Branch:

Gentlemen, we want to thank Doctor McBryde very much for this practical message he brought us this morning. I want to say that to my mind it is one of the best things I have ever heard presented to our Society. And I am sure those of you who heard it in its entirety feel well paid for your trip here to this convention.

I want to digress for just a moment and say to you that Doctor McBryde's father and mother are with us this morning from Michigan. It is their first trip to this part of the country. I am going to ask, if they don't mind, if they will just stand up in order that you folks may see them it will be appreciated.

I want everybody to meet them while they are here and make them remember their first trip here to the South. (Much applause.)

Dr. H. K. Thompson will introduce our next speaker.

Dr. Horace K. Thompson:

Mr. Chairman, ladies and gentlemen: The man whom I am going to introduce this morning is a member of the American Academy of Periodontology and the International Association for Dental Research. He is also Professor of Periodontia and Oral Pathology at the Medical College of Virginia.

Back in my school days, it was a pleasure to know Dr. Lyons as an A student and later instructor in the clinic. Were it not for the fact that it is customary to introduce the speaker, I should not be up here now. For Doctor Lyons as you will soon learn, can speak for himself.

Doctor Lyons has enlarged on the ideas and ideals of school days and the dozen years or more since that time have made of him a pathologist, a research worker, and, above all, a practical periodontist.

It is my pleasure to introduce Dr. Harry Lyons. (Applause.)

Dr. Harry Lyons:

Mr. President, ladies and gentlemen:

"TECHNICAL PROCEDURES IN PERIODONTOLOGY"

HARRY LYONS, D.D.S., Professor of Periodontia and Oral Pathology
Medical College of Virginia, School of Dentistry

Attention has been called to the biologic aspects of dentistry for innumerable centuries, dating back to the fourth century before the Christian Era when Hippocrates made frequent references to the teeth in his writings on medical subjects. Thru all the ages, similar references are to be noted. In our own country, for instance, Benjamin Rush, in 1818, recorded important observations on the relationship between diseased teeth and certain systemic ailments. These early reports, among many others, failed to arouse the general interest of either physicians or dentists.

Our present day appreciation of this phase of dentistry had its initial impulse in 1910. It was then that Sir William Hunter of England appeared before the Medical Faculty of McGill University in Montreal and denounced American dentistry in no uncertain terms, blaming certain dental practices for the occurrence of many systemic ailments and citing extensive clinical observations as proof. He pointed to the high degree of mechanical skill practiced by American dentists in almost total ignorance of the biologic aspects of the

dental problems. His lecture received extensive comment at the hands of the press and was effectively timed, since the X-ray and other laboratory procedures were just coming into popular use. The immediate reaction was one of intense interest in research bearing on dental pathology and centering around the pulpless tooth. In clinical practice, this interest found expression among a large number in a radicalism which is without parallel in medical or dental history. The "one hundred percenter" was born. Many now look back with regret on the part they played in this rôle, since time and the discovery of scientific truths have proven this extreme view to be an erroneous one. Of course, extremists still exist in this field, but there is ample evidence now to afford the intelligent dentist of today a definite classification of pulpless teeth and a reasonable prognosis for such teeth in their various involvements.

Dentistry today is experiencing another awakening in the biologic field. In its limited vision in years gone by, the dental profession overlooked, to a large degree, the biologic importance of periodontal diseases. It is not enough to maintain teeth free of caries and pulpal involvements. Mechanically, they must be maintained in position and, biologically, they must be maintained free of the periodontal diseases which we now recognize as of equal importance with other focal involvements. History is repeating itself and we find a similar type or radicalism prevailing in the field of periodontal therapy. You are told by some that the physical salvation of the human race depends upon the rapid and spontaneous elimination of pyorrhea by a radical type of surgery which would do credit to the barbarism of the dark ages. It is interesting to note that such surgical practices were first described in 1851; yet, today you are told that these procedures, somewhat refined but nevertheless almost a century old, are the latest discovery in dental therapy. The numerous claims for authorship now prevailing constitute one of the professional comedies of the age. More will be said of methods later.

Students in the better dental schools today are receiving sufficient training in the basic biologic sciences to afford them a working background on which to build an understanding and appreciative attitude toward this phase of dentistry. A great number of the older practitioners explain their lack of interest in this field on the basis that they were not fortunate enough to receive this background. If this condition amounted only to a lack of interest in a *subject*, it would matter little. However, translated in terms of practice, it means a lack of interest in and appreciation of the complete welfare of the patient. It means that this particular type of practitioner is willing to have patients leave his office under the impression that all their dental needs have been served whereas, as a matter of fact, an entire dental field has been ignored—to the patient's misfortune. One cannot continue to blame his elementary education for ignorance in adulthood; neither can one blame his undergraduate education for all his shortcomings in practice later in life.

The periodontium can be afflicted by many ailments. Some of these are purely local in origin but soon assume a wider significance. Others arise on a basis of systemic disease. Malignancies also occur.

The majority of periodontal involvements are of local origin and many of the contributing factors can be attributed to the dentist himself. Count up the overlooked and neglected malocclusion cases of childhood, lack of oral hygiene instruction and practice, unwarranted loss of teeth thru caries and pulpal disease, poorly constructed filling restorations with no contact, faulty occlusion and overhanging margins, poorly engineered bridges and dentures. The total of these etiologic agents must impress one with the degree of the dentists' guilt in contributing toward the development of periodontal involvements. Local etiologic factors which account for the majority of cases can be irritants of any or all for the four groups: mechanical, chemical, thermal and bacterial. To despair of finding a specific cure for a disease when its effective prevention is a simple matter of everyday practice is, again, evidence of the profession's lack of appreciation of facts definitely proven. While simple in origin, these cases soon take on such complications as infection and constitute a potential menace to human welfare.

In a limited number of cases, diseases of systemic origin or their symptoms become manifest in the periodontium. To be noted here are the symptomatic involvements seen in the leukemias, the acute dietary deficiencies, excessive drug administration, and possibly many other diseases such as diabetes which affect oral health but about which we have little exact knoweldge at this time. Such diseases as syphilis and tuberculosis actually induce their characteristic lesions in the periodontal field. In view of these facts, it becomes apparent that the dentist must be prepared to recognize the relationship existing between his responsibility and that of the medical practitioner.

To state that the dentist should be on the alert for malignant and pre-malignant conditions of the oral cavity is to repeat a frequent admonition. The periodontium is often the site of such disease. Every persistent tumefaction arising here should be subjected to a complete diagnostic procedure and a long period of post-operative observation.

As general practitioners of dentistry, you are interested mostly in the therapeutic procedures of value in the nonspecific and chronic cases of periodontoclasia which are so prevalent as to be observed daily in routine practice. While it is not the purpose of this discussion to detail a consideration of the systemic phase that may exist in some of these cases, it is nevertheless emphasized that this aspect of periodontal involvements must receive its proper attention if success is to be attained. This, of course, calls for coöperation with the medical practitioner. Locally, every dental procedure that can be mentioned short of two full dentures has a periodontal bearing—either for good or for evil. Every filling, bridge, partial denture, single full denture, extraction, orthodontic procedure, etc., tends either to maintain or improve periodontal health or else contributes toward its destruction. For this reason, among others, the general practitioner should have the highest possible appreciation of periodontology. The two most important local procedures of therapeutic value are the establishment of good dental function

and the treatment of the structural changes—the so-called periodontal "pocket."

The establishment of good dental function in the adult often necessitates bridgework, operative and prosthetic procedures. Certain occlusal and articular mal-relations at this age require correction by grinding. A great deal has been written about "grinding occlusion" but one is at a loss to find a clear outline of just what is to be accomplished and how it can be done. The first point to consider is what factors bring about the necessity for this type of treatment. The important factors here are: (1) Faulty occlusal restorations; (2) Malocclusion dating back to the dentitions; and (3) Changes in tooth position due to periodontal disease. The first factor mentioned requires no additional comment. The other two must be considered in more detail.

It is a common observation to see the periodontium normal in the presence of malocclusion dating back to childhood. This may cause one to doubt the relationship claimed to exist between malocclusion and periodontal disease. However, this finding can be rationally explained. In the absence of other etiologic factors, as long as the resistance manifest in the periodontium is in equilibrium with the existing occlusal stress, the periodontium will remain normal. To what age and thru how many physical stresses this state of equilibrium will persist is questionable and undoubtedly varies in each case. Experience will point out that sooner or later a disturbance sets in: hence, the indication for prophylactic or preventive correction. Further, in malocclusion where some teeth are in an afunctional relation while others are in a hyperfunctional one, it is unreasonable to assume that both extremes can exist in the same mouth without structural changes occurring at some time about one or the other.

The position of the human tooth is not definitely and rigidly fixed, either in health or disease. The lateral drifting of teeth following the loss of an adjacent tooth or proximal support is an everyday observation. This often calls for an alteration of the newly assumed occlusal relation. The human tooth also changes its position in another direction, *i. e.* occlusally. Elongation occurs both physiologically and pathologically. Physiologically, the human tooth is one of modified continuous eruption. One needs only to grind a tooth with a normal periodontium out of occlusion to note its physiologic elongation until it again occludes with its opposing tooth or teeth. Pathologically, the human tooth moves occlusally as the fibers of the peridental membrane are severed and as inflammatory swelling in the periodontium tends to force the tooth from its alveolus. These factors form the background of knowledge necessary for the intelligent occlusal and articular correction by grinding. One often finds that a correction obtained today disappears or fails to exist several days or weeks later. The reasons for this are several. First, the progressive periodontal destruction and the resulting tooth elongation were not arrested and, secondly, the subsequent physiologic elongation of disoccluded teeth was not taken into account and the wrong teeth ground. To obtain a reasonably permanent occlusal and articular correction, one must take cognizance of these factors.

The diagnosis of occlusal and articular malrelations involves principally the utilization of the cardinal methods of inspection and palpation. Carbon paper markings and casts are occasionally of limited value as adjunctive agents. Both of these present marked limitations of usefulness. The use of casts for the purpose of record is not as popular or valuable in periodontia as in orthodontia. The method of palpation as applied here might be explained. The left index finger is placed on the buccal or labial surface of the individual maxillary teeth and the patient instructed to open and close the jaws forcibly in centric relation. Excessive and unequal occlusal stresses not apparent on inspection can easily be detected by this simple procedure. The same technic is then carried out for all the articular relations, starting from the occluded centric relation and having the patient move the mandible thru all of its functional paths.

These mal-relations having been recognized, the next question to be considered is when to institute correction. There are those who advocate this as the first step in periodontal therapy while others suggest that it be the last. Neither plan affords all the advantages to be gained, since it is impossible to secure a satisfactory and reasonably stable adjustment at either time. Mal-relations which are obviously causative should be partially corrected early in the treatment of a case as part of a general program of removing causes of the disease, allowance being made for the subsidence of the inflammatory swelling in the periodontium and the accompanying retraction of the teeth. However, the correction of mal-relations resulting from periodontal destruction must be synchronized with the other phases of periodontal therapy. The logic of this statement becomes apparent when it is recalled that periodontal destruction and healing are both accompanied by tooth movement. This fact explains why the best results are obtained by gradually correcting these mal-relations as treatment of the case progresses.

The modus operandi of occlusal and articular correction warrants considerable explanation. The instrumentarium need not be elaborate. Small mounted stones, preferably S.S.W. Numbers 37 and 41, fine sand-paper discs and Burlew cones will suffice. The first step is to correct the centrically occluded relation so that the stress in this position is equally distributed. A choice is to be made here as to which of the two opposing teeth to grind when correction is indicated. Obviously, if a tooth bears a faulty occlusal restoration, that is the tooth to be selected. If elongation has occurred as a result of periodontal disease, the elongated tooth is shortened, even though this may be the more painful of the two opposing teeth to grind. The reasons for this choice are that a reduction of leverage forces on the elongated tooth is desired and an effort should be made to preserve or reëstablish the original occlusal curves if they are of desirable proportions. If the latter point is not observed, a marked interference may result when the mandible moves thru its various functional paths. Instead of establishing an even occlusal curvature, marked occlusal interlocking and a step-like arrangement will result. After the centric relations have been corrected, attention is given the various articular relations, starting with the protruded

incisal position of the mandible. In any of the articular positions, an inspection of the relation of all teeth should be made to note any interference that may prevent the free movement of the mandible with the opposing teeth in contact. Often, an anomalously placed third molar, an inclined second molar or a first molar which has elongated into an edentulous space will offer marked interference and the elimination of this must be secured before proceeding. Again, the problem arises as to the choice of teeth to grind. The important points to observe here are two: (1) not to disturb the previously corrected centric relation and (2) to so grind as to correct and yet prevent the subsequent physiologic elongation of the ground teeth. In other words, a tooth must not be disoccluded in centric relation in correcting its articular relation. For instance, where the maxillary incisors are in their proper labio-version to the mandibular incisors, an indicated correction in their *centric* relation may be made by grinding either the incisal edge of the mandibular incisor or the lingual aspect of the maxillary incisor, depending upon which tooth is the elongated one. However, if an articular adjustment is to be made in the protruded incisal position, that correction must be made at the expense of the *maxillary* incisor if the result is to be reasonably permanent. If the mandibular incisor is ground, this tooth will be disoccluded in its centric relation, physiologic elongation will quickly occur and the end result will be far worse than the original condition. The unfortunate lack of understanding of this principle explains the innumerable failures in this field. The two exceptions to this rule are in the cases with an open anterior bite and the cases of crossed-bite in prognathism. In the bicuspid and molar regions where these teeth are in their proper buccolingual relation, articular corrections on the working side are properly made at the expense of the maxillary buccal cusps and the mandibular lingual cusps. These are so ground as to eliminate cuspal interference and to equally distribute the stresses in the various mandibular movements. On the balancing side where the relationship is between the lingual cusps of the maxillary molars and the buccal cusps of the mandibular molars, the necessity arises for grinding one of these cusps which are ordinarily engaged in maintaining the normal bite. This correction is preferably made at the expense of the lingual cusps of the maxillary molars. Closure of the bite will not result as long as only this cusp is ground. However, should both of the opposing cusps in the balancing relation be ground, subsequently elongation of these teeth will occur. The ground teeth should be shaped to good anatomical form, the ground areas polished and desensitized by the application of concentrated phenol. Adherence to the plan and principles outlined is essential; haphazard and promiscuous grinding is not only of negative value, but of positive harm.

The treatment to be given the root surfaces and soft tissues of the so-called periodontal "pocket" should be rationally based on the underlying pathology. In this field, modern histologic studies have exploded many old fallacies and supplanted them with exact knowledge. It is not within the scope of this paper to discuss periodontal pathology, since that is a broad subject in itself. About this subject,

only such statements will be made as are necessary to rationally explain the advocated therapy and to refute the claim of others.

The existence of an unattached gingiva forming a gingival sulcus between itself and the tooth is the normal in the anatomic structure of man. Its depth varies widely and as has been shown, this gingival sulcus can reach markedly extended depths without precluding the possible health of the tissues. There is, then, every reason to conserve and no reason to destroy this anatomic arrangement. Any radical procedure designed to destroy this is unsoundly based. Many unfavorable local conditions result from such a practice and the irony of it is that a new gingival sulcus is soon established, deformed. misplaced and abused tho it be.

Another old fallacy, now exploded by histologic studies, is that radical bone scraping is necessary because the alveolus is necrosed in chronic periodontoclasia. The resorption of vital bone and bone loss by necrosis are two entirely different pathologic entities. In chronic periodontoclasia, resorption of the vital alveolar bone does occur, but no alveolar necrosis occurs nor can the bone be reached unless very valuable soft tissues are first destroyed. Quite on the contrary, regeneration of alveolar bone which can be secured starts from the vital spicules seen in X-rays and about which the radical clinicians enter into so many spasms of dementia.

Whatever the reasons may have been for advocating radical procedures in the dark ages of dentistry, they have all been refuted by our newer knowledge and the development of a finer technic made possible thru better instruments. The following comparison may be drawn. A patient presents a finger irritated by an imbedded splinter. Obviously, the logical and conservative treatment would be to gently remove the splinter. If this proves impossible by unequipped, unskilled hands, the finger can be amputated and the splinter irritation relieved in this way. In periodontal therapy, one can choose between these same two extremes. Where calcareous deposits on cemental surfaces irritate the soft tissues, they may be gently removed by conservative curettage or the soft tissues may be cut away from the irritating calcareous deposits. Indeed, it has been pointed out that the indications for radical procedures exist in inverse proportion to one's ability to perform conservative curettage. It is to be noted further that the surgical removal of any part of the periodontium cannot possibly prevent or remove bacterial invasion and infection nor can it eliminate any of the etiologic factors responsible for the disease. The only thing it positively does is to create or add to the local deformity and discomfort of the part and to preclude possible tissue regeneration. One's insistence on radical practices infers either an ignorance of periodontal pathology or a lack of sufficient digital skill to perform the more exacting conservative technic which enables one to conserve tissues and, in many instances, to stimulate regeneration and reattachment.

It is obviously impossible for one to impart digital skill by lecture or correspondence. That requires personal application along well directed lines. One must select the types of curettes, planes and files which suit one's personal idiosyncrasy. A knowledge of dental anatomy is an important prerequisite. On this, one must base the

intelligent application of the selected instruments and acquire that degree of touch necessary to locate root-accretions and to know when their complete removal has been accomplished.

The field of periodontal medication warrants some discussion. Based on the newer knowledge in this field, one must conclude that nothing can equal a blood-clot as a post-operative dressing in a periodontal lesion. The use of a paste, or powder dressing in these lesions delays or interfers with the healing processes. To secure connective tissue re-attachment of the gingiva to the cementum, one must permit or establish immediate approximation of these parts devoid of the epithelium which grows down the inner surface of the gingival tissues. Experience has taught that the instrumentation plus the acute post-operative local reaction are quite sufficient to destroy this epithelium. Sodium sulfide preparations can be used. Gas insufflation, ointment inunctions, ultra-violet radiation, vaccines, and the immortal faith in highly colored solutions are of no value and may result in harm to the patient. During the immediate post-operative period, normal saline warmed to approximately body temperature is of value. The important adjunct to the advocated treatment is the appreciation and practice of good oral hygiene on the part of the patient. As someone has so ably stated, the really important drugs in dentistry are the fluid extract of common sense and the tincture of good clinical judgment.

This paper was followed by lantern slides illustrating problems in occlusion, periodontal pathology, instrumentation, and X-rays of cases illustrating bone regeneration.

President Branch:

Gentlemen, I believe we are all agreed that our sister state sent us a lion and a bearcat, too. We are mighty glad to have Doctor Lyon with us. I wish we had time to devote a good many minutes to questions.

I would like to call your attention to the fact that our program for this meeting is dedicated to one of the deans of dentistry, one of the grand old men—if you will pardon me—Dr. W. T. Smith, of this city. I want Doctor Smith to stand up. (Applause.)

We must not be in such a rush that we fail to recognize our friends who come to us from the medical profession and the dentists from other states. I notice Dr. Guy Harrison has just come into the room; we do not have time to hear from him, but we do want him to stand up. (Applause.)

We are mighty glad at this time to ask Doctor Lineberger to introduce our next speaker.

Dr. H. O. Lineberger:

Mr. Chairman, members of the North Carolina Dental Society: The North Carolina Dental Society, like the state societies all over this country, is faced today with a tremendous problem. Your Program Committee was aware of this fact and they sought to bring to this meeting here today one of the foremost men in this line, of socio-economics, in this entire country of ours, to direct our thinking and our meditations in that direction.

And gentlemen, without further to say, it gives me great pleasure to present at this time, Dr. Bissell B. Palmer, of New York City, who is now to address you. (Applause.)

Dr. Bissell B. Palmer:

[Dr. Palmer's extemporaneous address having followed the same general outline as the address delivered before the annual meeting of the New Jersey State Dental Society, his permission has been secured to reprint the body of the New Jersey address.]

Mr. Chairman, Doctor Lineberger, members and guests of the North Carolina Dental Society: It has been well said that there are three groups in general society: One group makes things happen, the second group watches things happen, and the third group does not know that anything is happening. It is because that I know that this North Carolina Dental Society belongs in the first class and makes things happen, that I am particularly happy for the privilege and the honor of coming before you today.

When I say that you make things happen, I recall the resolutions that you have passed in opposition to dental advertising propaganda; your resolutions on dental journalism; your active support of dental journalism in the establishment of your own *Journal of the North Carolina Dental Society;* Doctor Lineberger's active participation in the work of the Commission on Journalism of the American College of Dentists. All these things make me feel that we have very much in common and especially happy to come before you.

Your committee has asked me to speak on health service, socio-economics. It is a formidable subject to be asked to speak on; it is almost like asking a man to bail out the ocean. One doesn't know just where to begin; one hopes, but would not be sure just where one should end. I hope that I will know when to end so that you will not recall the story told of an old colored man, I presume from this part of the country, who wanted to divorce his wife and went before the judge and expressed such a desire. The judge said, "Well, why do you want a divorce?" and the plaintiff said, "Well, my wife she talk and talk and talk." And the judge said, "Well, what does she talk about?" and the darkie said "Well, she don't say." (Laughter.) I hope when I am finished my discourse that you will not think of me in similar terms.

Seldom, if ever, in the history of our profession has there been such bewilderment over a major problem as now exists in relation to the discussion of social changes in dental health service.

Consideration of other important general questions has been temporarily postponed so as to focus full attention on a problem that is so important, and so extremely complex, that decisions in relation to it will directly affect the economic, social and cultural status of every dentist in the United States. The decisions to be made will also affect the 123,000,000 of our country's population, for the extremely vital question of public health is directly involved.

As is the case with so many other problems, it is frequently found that early solution is expedited by a consideration of the fundamental principles involved. In studying the relationship of our profession to the conditions arising from current social trends, we might effectively resort to such a method of approach.

In any discussion of the future of Dentistry, we must not lose sight of the reasons for our existence as a health service profession. Primarily, we are a public health agency. We assumed this privilege and obligation when we asked of our state legislatures, statutory regulation to prevent others than licensees from practicing dentistry. State licenses to practice are granted only on the conditions formulated and imposed by our profession. In so limiting the practice of dentistry to those who meet our specified requirements, we become the only body in the State capable of and legally qualified to protect the public health in its dental aspect. There being no other group to which the public or the state government can turn for a progressive program of health service, we find ourselves in a position of tremendous responsibility. We cannot become static in our concepts of our public service functions. We must be constantly attuned to the wave-lengths of public needs, and alert to the audible expressions of those needs as broadcast from the progressive legislators.

Another fundamental to consider is the fact that Dentistry is a profession and not a trade. It has been well said that: "Trade is occupation for livelihood; profession is occupation for the service of the world. Trade is occupation for joy of the result; profession is occupation for joy in the process. Trade is occupation where anybody may enter; profession is occupation where only those who are prepared may enter. Trade is occupation taken up temporarily until something better offers; profession is occupation with which one is identified for life. Trade makes one the rival of every other trader; profession makes one the coöperator with all his colleagues. Trade knows only the ethics of success; profession is bound by lasting ties of sacred honor."

In keeping with the doctrine set forth in the foregoing, it becomes obvious that we must adopt and practice a high-minded philosophy for the dental profession. Contrary to the teachings of the itinerant, commercial vendors of courses in dental economics, we are not engaged in a business; nor is it our primary purpose to exact from the public all the "traffic will bear" in remuneration for our services. We are members of a profession that has accepted the sole responsibility for the dental health and comfort of a whole population. To emphasize our professional concept, it might be brought out that all dentists would be delighted beyond measure, if through our researches we could end all dental diseases, so that there would be no

further need of a dental profession. Under such a development would we not all be joyfully willing to make such personal adjustments as might be necessary, and enter other fields of endeavor, happy that we had been part of a profession that had contributed so much for the benefit of mankind? If a similar accomplishment were possible in medicine, would not medical practitioners be supremely happy that all disease had been eliminated? Would not the consciousness of participation in such an accomplishment be sufficient compensation for any personal inconveniences for physicians that might result from such a development? If as groups we did not harbor such reactions and sentiments, then we would be unworthy of the appellation—profession.

It being established that we would gratefully welcome any development that would be productive of widespread dental health for the masses of our population, does it not seem logical that we should be the initiators of and participants in any movement that will tend to deliver the population from the present scourge of dental disease with all its destructive sequelæ. With these purposes in mind, surely it will be agreed that as a profession we would wish every man, woman and child in the United States to know the importance of dental health; to be educated to the doctrine of prevention, and to have made available to them the skill, ingenuity, and scientific capabilities of a profession acknowledged the world over to be without a peer in dental functional therapy. Believing this point to be established and indisputable, let us turn to another phase of the situation.

Beginning in the Middle Ages, the consciousness of the desirability of contributing to mutual funds in time of health, for the care of members of the contributing groups in time of illness, has gradually attained broad development. Through a long process of evolutionary social changes, health insurance in one form or another has spread so widely that today but few of the important nations of the world have not adopted it. Countries that have either voluntary or compulsory health insurance today are: Argentina, Austria, Belgium, Bulgaria, Canada, Chile, Czecho-Slovakia, Denmark, Esthonia, Finland, France, Germany, Great Britain, Greece, Hungary, Irish Free State, Italy, Japan, Latvia, Lithuania, Luxemburg, Netherlands, New Zealand, Northern Ireland, Norway, Palestine, Poland, Portugal, Roumania, Russia, Spain, Sweden, Switzerland, Union of South Africa, Uruguay, and Yugoslavia.

The days of the stage-coach, the pony express and the trans-oceanic sailing vessels are gone forever. Today we have the high-speed ocean liners, the airplane, and the radio. A message can now be projected from Washington, and in a few minutes be read in the farthest corners of the world. International communication today is almost instantaneous. Political, social and industrial changes develop more rapidly in these days for just this reason. Evolution in all these fields has been geared up. The changes that formerly were slowly developed in the course of a genration are now accomplished in a few years. In addition to changes in methods of communication, our advances in universal education and the general adoption of the doctrine of freedom of thought and speech have contributed no little to this speeding up program. Lecturers, imbued

with the enthusiasm born of inspiration for causes, are enabled to travel the world over, and spread their teachings. Frequently their Utopian concepts of sociological and political problems find willing ears and impressionable minds. The seeds sown bear ample fruit and are soon replanted in thousands of fertile fields. Our newspapers and magazines publish translations of works of authors from nations spread over the entire earth. Our current events clubs, speakers' societies, motion picture news reels, and radio programs are a constant source of miscellaneus information on innumerable questions of national and international consequence. The achievemets and inadequacies of the socio-political doctrines being currently promulgated, particularly in the United States, Russia, Italy, and Germany, are recorded and studied by interested groups the world over. Consequently, no nation can consider itself as being insulated against the changes produced by the trends of the day. Science, industry, religion and art become involved in these changes and, if logical, we cannot expect the health service professions to be uninfluenced by the developments.

When we use the term "trend" in discussions of socio-economics we do so to indicate the tendency of a number of related or unrelated sequential events to forecast an ascertainable ultimate. For instance, during a prolonged period in history there was a trend toward democracy in national governments. In recent years there have been indications of the development of a trend toward dictatorships. The tendency of physicians and dentists to enter the practice of specialties might properly be referred to as a "trend." In the United States for the past twenty-five years there has been an unmistakable trend toward social legislation. When we speak of "social legislation" we refer to that legislation that has for its purposes the bettering and safeguarding of living and working conditions for great masses of the population. One favoring such progressive legislation need not embrace socialism as a political doctrine, nor need he be known as a "Socialist." To emphasize this point it is only necessary to point out that the major political parties in recent years have sponsored legislation that twenty-five years ago would have gratified the most radical Socialist. Let us review briefly some examples of social legislation that are already a part of the law of the land. Of course compulsory education provided by the state was one of the first examples of social legislation enacted in this country. Other examples of social legislation of particular interest will be found in our public health services. In this category may be listed compulsory vaccination and state sanitation laws covering such items as food inspection, sewage disposal, and smoke nuisance. Also, we have state provision of asylums for the insane, and clinics and hospitals for the health service of the indigent. In reviewing the social legislation already enacted we must not forget the maximum rent laws of a decade or more ago, or the present submission of the Federal constitutional amendment prohibiting the employment of children in industry. Passing for the moment any reference to the social implications in the NRA rulings, let us consider some other examples of social legislation that seem certain of early enactment. First, old age pensions. President Roosevelt has endorsed this proposal and

important individuals are currently making public addresses to arouse interest in and support for such legislation. Another development we may soon expect is State or Federal unemployment insurance. The legislature in New York State has such a law now under consideration. Secretary of Labor Perkins has recently held a number of conferences with the state governors regarding this issue, and in view of the support of the present administration for the measure an unemployment insurance law seems certain of adoption in the not distant future. Surely the foregoing will serve to convince the most skeptical as well as the most conservative that there is an unmistakable trend in this country toward social legislation. If this statement is accepted then it must be agreed that the same forces that are producing these social changes will not stop short of making health service available in all its branches, including dentistry, for our 123 million population. The validity of this opinion is emphasized by the fact that today the United States is the only leading nation in the world without health insurance. Included among the thirty-seven countries that have provided this form of health service for their masses of population are the most powerful and highly respected nations of the world. Will the United States resist this trend? Trained legislators, sociologists and economists are emphatic in their opinions to the contrary. One other indication that social legislation affecting the health service professions is imminent, and not just a possibility for some remote future date, is that the enactment of unemployment insurance legislation, which has been advocated by President Roosevelt as a part of his social program, will make early health insurance inevitable. It is a companion piece of legislation. One is not workable without the other. When a man becomes ill, he loses his job, and under unemployment insurance he begins to collect money benefits. The agencies making such cash payments want that man to get well and to return to work as soon as possible, in order to terminate the benefit payments at the earliest moment. To attain this end it is necessary that such a man have medical or dental attention. If the man is receiving only enough in unemployment benefit payments to keep a roof over his head, and sustenance for his body, how can he pay for his medical or dental care? How can the insurance agency ascertain whether the man is really ill enough to justify benefit payments, and how can they ascertain when it is safe for the man to return to work? These and many other interrelationships, as well as observations on social legislation in other countries, indicate that health insurance in some form is an inevitable companion of unemployment insurance legislation.

Now that it has been definitely established that there is a probability of near term social legislation that will vitally affect every dentist in the United States, the question arises regarding what we are to do about it. The answer can be found in the experiences of the medical and dental professions in the other thirty-seven countries where such legislation has been enacted. In every nation in which the professional leadership has been unseeing, insensitive to current trends, stupid, obstinate, or belligerently opposed to such legislation, the laws have been enacted despite that indifference or opposition.

The unsympathetic attitude of the professions in such instances has always resulted in most unhappy aftermaths, for the antagonized public and legislators subsequently denied the professions any part in drawing up the insurance legislation. In consequence, the interests of physicians and dentists received but scant consideration in the legislation, which in some instances was poorly drawn up as to become a menace to public health. Years of effort, large assessments on members of the professions for funds for a legislative lobby, and a complete rebuilding of public esteem, became necessary to modify the undesirable legislation. Among collateral evils resulting from a combative attitude on the part of the professions have been: (a) inadequate compensation for physicians and dentists; (b) lowering of the status of and respect for the professions; (c) depreciation of the quality of service to the public; (d) injection of commercial or political control of the health services, with a subsequent dropping of the bars allowing nongraduates to practice, with resultant fee wars between that group and the graduate practitioners. This debacle must not be permitted to occur in the United States.

Before proceeding further in this presentation, it would seem appropriate to first define some elementary terms used in discussing socio-economic health service questions.

By production we mean the process of providing health service by a practitioner.

By consumption we mean the utilization of the health services of practitioners by the public.

By distribution we mean the system or agency through which the consumer receives the production.

When we speak of state medicine we mean that the government, the distributor, takes full charge of providing health services to the consumer, the public, and employs for the purpose the practitioners, who are the producers.

By insurance medicine we mean the establishment of a fund through premium payments, so that the insured may receive health service paid for by the funds so set up. Insurance medicine may be either voluntary or compulsory. In the latter system, legislation is enacted making it necessary for all employees receiving less than a specified annual income to become insured.

Panel medicine is really not a separate system of medicine, but instead it describes but one method of distribution of patients, generally under an insurance system. Primarily it consists of a list of practitioners who have expressed a willingness to participate in the plan of providing health services under the socialized system. The term has also been used in referring to the list of patients allotted to such practitioner.

Fee Scale is a term that refers to the schedule of remunerations agreed upon for health practitioners who serve masses of population under a socialized system of medicine, whether it be emergency (temporary) or statutory (permanent).

The Clinic System is the antithesis of the private practice system of health service. The clinic system is practiced in some of the socialized European countries, especially in Soviet Russia, and con-

sists of groups of practitioners working under supervision in a public clinic. The philosophy underlying such a system is mass production, with reduced overhead expenses, and a consequent lowered cost for the patients, principally at the expense of the practitioners.

Pattern is the term used to indicate the establishment of a preliminary plan or method for providing socialized health service. Patterns may be set up to indicate: (a) the kind of system, whether state or insurance; (b) under the latter system, whether the private or clinic type of practice; (c) forms of remuneration, whether by salaries, fees or per capita; (d) wage groups eligible for the service; (e) extent of services to be rendered, etc.

European experience has taught the health service professions in America many useful lessons, but none more important than the significance of patterns. In this connection it might be useful to call attention to the fact that legislation to socialize health service generally appears at a time when there is general unrest and dissatisfaction in a populace due to economic and social conditions. During this period the health service practitioners suffer no less than the masses. Consequently, a large proportion of the members of the professions at such a time recognize the need of (1) providing services for those groups of the population unable to pay standard fees, and (2) providing patients for that group of pracitioners unable to subsist on the meagre income derived from their depleted private practices.

With this double-acting incentive pulling the professions toward a change, and with the legislative demands of large masses of voters pushing in the same direction, the end result has generally been some form of socialized health service. Prior to the enactment of such legislation, however, the professions, in an attempt to temporize or compromise the situation, often establish certain emergency devices to alleviate conditions for both the public and the profession. Here is where the great danger lies, for this is the establishment of a pattern.

Initial plans may later be greatly elaborated or extended, but they follow the original outline. For instance: European experience indicates that if the first step consists in setting up a low fee clinic for certain of the low income groups of workers, the clinic system invariably develops as the national system of health service. Such systems always expand. If the original beneficiaries under the system are limited to the group earning but six hundred dollars per annum, in a few years the legislature, under pressure, raises the limit to include income groups of nine hundred to a thousand dollars. In a few more years the group entitled to health service includes not only those employees within the specified wage groups, but also their immediate families. Thus the system expands steadily, and generally on the pattern originally laid down. It is unnecessary to go over to Europe or back through the years to find an example of the importance of a pattern in socialized health service. In 1932, New York State voted an appropriation of $15,000 for dental relief. It was decided to spread the work over a period of ten weeks, and to limit the sum paid any one dentist to $150. Thus each dentist, over the

period, received the equivalent of $15 per week. Thus we had a remuneration pattern established during the emergency. This arrangement was made under the supervision of the New York State Emergency Relief Committee. In May, 1933, a plan was presented to the Dental Society of the State of New York providing free universal dental service for children, with remuneration for part-time dentists again fixed at $15 per week. Later, in 1933, in New York City, an emergency dental relief program was inaugurated under the auspices of the city health department and once again $15 per week was the remuneration paid dentists for part-time services.

How did the authorities arrive at this figure of $15 per week? The answer is that a pattern, or a precedent, had been set up previously in what had seemed to be an innocent emergency arrangement. It is thus obvious that we must exercise the utmost caution in establishing these primary patterns, even when the occasion may seem quite devoid of the possibility of providing future repercussions. Original patterns, developed in a moment of panic or as a result of weak or misguided leadership, may establish the basis for a future system of health service that will demoralize the professions, and deteriorate the quality of their service to the public.

It seems certain that the social trend is toward the development of a system of medicine and dentistry for the large masses of population economically unable to avail themselves of health services under our present system. As a profession, we are obligated not only to provide such services, but also to coöperate in producing such a system. How are we to do it? First, we must study. We must familiarize ourselves with all that has gone on before. We must examine carefully the experiences of the professions in Europe, and profit by their mistakes. It is suggested that practitioners read and re-read "The Way of Health Insurance," by Simons and Sinai, published by the University of Chicago Press. This book was written by two scientific investigators who went abroad to study the experiences of Europe in health insurance. The survey was sponsored by the American College of Dentists and is generally acknowledged to be the most valuable work ever done in the field. Only with such a background as this book provides can we approach our problem with the knowledge and understanding necessary for its effective solution.

A careful study of previous experiences in socialization of medical and dental services indicates that in order for such a system to be made workable in this country certain fundamental principles must be taken into consideration. Here in the United States, despite all rumors to the contrary, we still have a democratic form of government. Also, we have a system of economy in which profits are permissible and, at least theoretically, are directly related to the degree of intelligence, technical skill, and profoundness of application of an individual to his chosen work. Under such a combination of political, economic and individualistic factors it would be obviously impracticable to transplant to the United States an European system of health service, designed to work primarily under a Communistic system of government, and a Marxian or Stalinistic doctrine of

economics. This statement is made without attempting to evaluate the comparative values of either system.

When we speak of an effective health service system, we mean one that provides both quantity and quality of such a service sufficient to meet the requirements of the population; and provides compensation for the ministration of such services, (1) commensurate with the amount of time and money expended by practitioners in educating and preparing themselves to adequately perform health services, and (2) sufficient to secure the cultural activities and happy living conditions so essential for practitioners of a health service, if they are to be humane, ambitious and effective in their calling. An acceptable plan must also retain the attractiveness of the health service professions, so that they will continue to draw to their ranks practitioners with the essential characteristics necessary for the rendering of a high quality of service, and who can be depended upon to continue to advance the science and art of the professions. Any health service system that fails to meet these fundamental requirements is foredoomed to failure, and will create chaos.

There are only two ways in which health service can be provided for the population in the lower brackets of income: (1) by taxation of citizens, or (2) by some form of health insurance. With the present almost intolerable burden of taxes, it would seem practically impossible to increase them to the extent required to finance a socialized health service. If this statement may be accepted as sound, then we may turn to a consideration of health insurance.

Now the advantages of a health insurance system are primarily twofold: First, it provides health service for the masses of population, who have heretofore received practically none, rendering this service at a cost the low income group can pay. Second, health insurance provides a back-log of patients, and consequently tends to provide a professional income that should be a reassuring anchor to windward during periods of national economic storms.

Health Insurance, despite its advantages as a system, may, under certain conditions, also carry serious liabilities. These hazards are found mostly in the provisions of the inequitable plans conceived and promulgated by lay bodies. Such movements gain headway only because of a lack of interest on the part of the professions when insurance plans are being discussed. To avoid these liabilities, it is imperative that the professions unite in demanding that certain provisions or safeguards be included in any system of health insurance advocated for adoption in the United States. The following are among the most important essentials of an acceptable health insurance plan:

1. Free choice of practitioners and patients must be assured. If we are to preserve the professional aspects of our calling, and retain our self-respect, we must have the privilege of declining to accept any patients whom we do not wish to include, or continue to retain in our practices. This provision works both ways, and patients must not only have the privilege of free selection of practitioners, but also of terminating the relationship should it prove to be an unhappy or unsatisfactory one. Only under such a mutually protective ar-

rangement can a system of health insurance succeed in the United States.

2. The private practice system of health service must be continued. The clinic system of health service, with its regimented personnel, is not an acceptable substitute for the present private practice system in the United States. The establishment of a clinic system creates a mechanism by which a distributing agency can force groups of practitioners to compete economically with each other, and thereby reduce professional remuneration and living conditions to an intolerable degree. A clinic system, in its ultimate development, means a foreman and workman relationship between practitioners and supervisors, and chain-store philosophy of health service. It means an overemphasis on reducing costs of service, including remuneration to practitioners, which constitutes the principal cost. It eliminates the freedom of professional activity and individuality, two of the features that attract individuals into health service professions. A clinic system tends to destroy that traditional personal relaionship between practitioner and patient which, in the minds of the public, has become an inseparable part of our American system of health service. No logical reason can be advanced for discontinuance of the private practice system of health service in the United States, unless the professions are unwilling to adjust their private practice systems to meet current requirements and changes.

3. Professional remuneration must be adequate. Any scale of remuneration that tends to impoverish the professions makes practitioners dissatisfied and unhappy, and reflects itself directly in an involuntary lowering of the quality of services rendered. We must devise a system that will assure appropriate compensation for health service practitioners, but which will at the same time provide services at a cost that may be borne by the low income group.

4. Quality of service must be maintained. The scope of health service provided under any insurance system must be sufficiently limited so that practitioners may equitably devote sufficient time to the proper performance of each service, and not be forced to sacrifice quality for expediency.

5. Commercial control of health service must be prohibited. Profit seeking agencies, acting as distributors, cannot be tolerated in health service. Their entrance into the field invariably inaugurate a three-cornered war, in which their main objective is to reduce costs to the distributing agency, at the expense of the practitioners. As the primary motive of the commercial insurance corporation is to make money, it becomes obvious that consideration of other important factors will be considered secondary to profits.

6. Political control or interference with health service is intolerable. When politicians come in the door of health service, efficiency in organization, quality of service, happiness of practitioners, and too often honesty, go out of the window. In some of the present dictator systems of government in Europe, political grafters are stood up against a wall and shot. In our easy-going system of government, too often these rogues are retired and given pensions. Until an outraged public opinion rises in wrath to terminate this plague, dis-

honest politicians will always be with us, and they must be allowed no place in health service.

7. The dole system menace must be avoided. One of the most outstanding lessons for the professions in the United States to learn from European experience is that the provision for health service under an insurance system must be kept absolutely apart from any question of cash benefits for the patient. In some of the European countries where such a combination of health service and cash benefits is providd for by law, the practitioner is caught between two terrific forces: (1) the power of the distributing agency, which demands that the practitioner, under penalty of incurring the suspicion and displeasure of the agency, take the patient off the cash benefit list even before the practitioner is willing to agree that the patient is well enough to return to work; and (2) the pressure that is brought to bear on the practitioner by the patient, who insists upon being kept on cash benefits even after the practitioner believes him fit to return to work. If the practitioner incurs the displeasure or dissatisfaction of his patients in this respect, he is quickly listed as too hard-hearted and he loses a large part of his insurance practice. American practitioners of health service must not be subjected to this cross-fire, which is intensely demoralizing to the professions. The only way to prevent it is to eliminate cash payments to patients as a part of health insurance.

While there are numerous other pitfalls in health insurance which must be guarded against by the professions, almost all of them are more or less related to those just described.

It is the duty of every health service profession to see to it that its membership is educated along socio-economic lines so that the commercial corporations, the opportunist politicians, both lay and professional, and even well meaning but sometimes overzealous philanthropic agencies, may not impose their respective wills upon uninformed professions to the detriment of practitioners and the public health.

The health service professions in the United States must avoid the costly mistake made in Europe where, in too many instances, reactionary professional leaders stuck their heads in the sand and thereby convinced themselves that no changes were occurring in the world around them. Stupidity or indifference on the part of the professions will lead only to disaster.

In the State of Michigan, about three years ago, the state medical society adopted a resolution opposing socialized medicine. The reaction on the part of the public as expressed in the editorial columns of the lay press was unmistakable. The resolution aroused such antagonism that the society almost immediately appointed a committee to study the situation. In July, 1933, the committee presented its report. The committee was continued and authorized to proceed to the development of a plan of health service for the State of Michigan that would meet the requirements of the situation. After further intensive study, including a survey of the present status of health insurance in Europe by Dr. Nathan Sinai, who went abroad for the purpose last December under the joint authorization of the

Michigan State Medical Society and the American College of Dentists, the committee presented its report and a plan on April 12, 1934. The House of Delegates of the Michigan State Medical Society adopted the report and the plan in principle by a vote of 61 to 9, and the lay press of the state immediately recorded its approval of the medical profession in enthusiastic editorials.

It has been learned that health insurance laws will be introduced in the legislatures of forty states in January, 1935. What the form of the proposed legislation will be is not known, nor do the professions have any definite knowledge as to whether objectionable provisions will be contained in such legislation. It is not known whether control of health service will be vested in the professions, or in some other agency. The health service professions of the State of Michigan, however, have no fear of this pending legislation, for they know that the professions in that state, having recognized their responsibilities, will have a working plan in operation long before the proposed legislation can be introduced. It is highly improbable that any legislature will attempt the passage of health insurance legislation in a state where all the health service professions are united in developing such a system, and where industry and labor are cooperating with the professions in the project.

The Michigan Mutual Health Service Plan is viewed by the Michigan State Medical Society as an experimental one. It is offered with the hope that professions in other states will be able to improve upon it. It is planned to put the system into operation within the next few months, but during the experimental period the plan will be operated in only one or two counties. At the end of a year, and possibly much sooner, necessary adjustments in the plan will have been made, and it is believed that by the end of this period the Mutual Health Service system will have proven to be the long-sought-for solution of the perplexing problem. Briefly, the plan calls for the setting up of a state body of control, known as a Board of Governors, consisting of three physicians, one dentist, one pharmacist, one registered nurse, and one hospital superintendent, all chosen by their respective state professional organizations. The board will be further augmented by its selection of two representatives from industry and two from labor. Local medical, dental, nursing, pharmacy, and hospital committees will be organized, and their respective chairmen will constitute, together with the local representatives of industry and labor, the District Mutual Health Service Committee.

Families having an income of $1,500 or less will be eligible for the insurance. The premium per annum will be $27.88 and its payment is to be arranged between industry and labor. The premium amounts to a little over fifty cents a week and can be paid either by the employee, the employer, or be apportioned between them. The premium may be paid weekly, monthly, semiannually, or annually.

The insured is entitled to receive office, home or hospital visits by general medical practitioners, and the services of medical specialists when necessary. Provision is also made for hospital bed, operating room, laboratory services, dressings, medicines, etc. The insured is entitled to twenty-one days hospitalization per annum, and should

an illness confine him to the hospital for over twenty-one days but less than ninety, Mutual Health Service pays seventy-five per cent of the per diem hospital charges for the additional period. The insured is entitled to thirty days of special nurse service and sixty days of visiting nurse service.

General medical practitioners, general dental practitioners and hospitals each receive $5 per capita per annum from the Mutual Health Service funds, which accounts for $15 of the $27.88 premium.

Each practitioner is limited to one thousand patients, which, with a full "family list," would bring him a gross income of $5,000 per year. One of the important features of the plan is that it is elastic enough to make it possible for states, towns or cities to arrange for the care of indigents by a contract with Mutual Health Service calling for the same premium and service.

A dental committee in Michigan is now working upon the details of the dental phase of the plan. The committee will deliberate on such questions as the scope of dental services to be rendered, the prosthetic restoration problem, fees for dental specialists, etc. It is to be hoped that the committee will point out the present inequitable dental representation on the Board of Governors of Mutual Health Service. As proposed, there will be three physicians on the board, exclusive of the hospital representative, who may also be a physician. Dentistry is given but one representative on the board.

In this presentation time will not permit of a discussion of all the details of the Michigan Mutual Health Service Plan. However, it can be stated that none of the objectionable features of health insurance that have been referred to in this paper are contained in it.

This would seem to be an appropriate time to emphasize that the dental profession should keep shoulder to shoulder with the medical profession in taking action on health insurance proposals. If the medical professions in the broadest sense of the term, including physicians, dentists, pharmacists, nurses, and hospital superintendents, unite in such a program, it must be successful. If the professions are split up, and if one group adopts a narrow plan applicable only to its own group of practitioners, only failure and confusion will result.

At the present moment the entire future of the dental profession is hanging in the balance. The next twelve to eighteen months will undoubtedly decide the issue. All questions of dental education, research, journalism, and technology must temporarily take second place to the solution of the socio-economic problem which confronts us.

It is generally conceded that the world's leadership in dentistry rests in the United States. The expenditure of $16,000 by the American College of Dentists on a study of health insurance in Europe by Doctors Simons and Sinai as early as 1930 would seem to justify the opinion that in this socio-economic crisis, Dentistry is consolidating its position of leadership. This would seem to be further borne out by the constructive contributions of the dental members on the Committee on the Costs of Medical Care, and by the active participation of well-informed dental economists in the numerous developments that are now coming to a head.

I believe sincerely that the next twelve months will determine the fate of the medical and dental professions of the United States. I think what is going to happen in the year will have a lasting effect on the professions. Therefore, it is absolutely essential that we guide those events, see that certain things do not happen, and that certain things do happen.

Now, there are three schools of thought in socio-economics. We have the *reactionist*, composed of "status quo" dentists who have successfully established their private practices and their personal incomes, and who are not interested in dentistry as a health service profession that has responsibilities to the entire population; they view this present situation as just an off-shoot of the depression; their doctrine is "Wait awhile, we will weather the storm, this economic storm will blow over when we dentists are making money again and the people have jobs again, and they will not talk any more about health insurance. This is just a part of the depression and let's not get excited now." Now these are the status quo men, the reactionists; the type of men who got the European professions into trouble. Be careful of the reactionists. Then we have the *Federalists*. The Federalists are those persons who think that we should have a system of state medicine, where all dentists, all medical doctors, all nurses, all pharmacists, all hospital staff members, are government officials. They would be employees of the state and absolutely controlled in all their actions by the state. We do not find the Federalists only among the politically radical Socialists and Communists, but we have plenty of them in dentistry and medicine, and if you haven't any of them down this way, you are fortunate indeed. The third group is the *Mutualists*, and I try to think of myself as a mutualist. I advocate some plan of health service that will provide adequately for the professions, that will provide adequate service for the public, that will look out for industry, and that will look out for labor; they are all represented, therefore we are justified in referring to that as a mutual plan. Understanding the North Carolina Dental Society as I do, and knowing the progressive group that you are, I cannot believe that you view this whole problem with the eyes of *Reactionists*. You cannot submit to state medicine or state dentistry; therefore, you couldn't be classified as *Federalists*. I therefore assume by the process of elimination that you can be nothing else but *Mutualists*. Feeling that way, you are urged to wake up to this situation as you have never roused yourself to any other problem. Appoint a committee and put it to work and have it approach every man in the profession in this country who has done any work along socio-economic lines; provide your committee with the funds they require and the books they need, and approach the medical society in your own state; find out what they are doing.

I do hope that all the stress that I have put you under in this last hour or more you will be impressed with the importance of the problem and that ont of it all will come the kind of plan from North Carolina I would expect from your State. I thank you for the privilege of coming before you. (Applause, much applause.)

President Branch:

Gentlemen, don't leave. For just five minutes we have Doctor Bear, who is trustee of the American Dental Association from this district. We want to give Doctor Bear just five minutes, he has something to say along this line. Doctor Bear.

Dr. Harry Bear:

Mr. President, Doctor Palmer has given us a very fine discussion of this subject of socio-economics.

There are a few things that I would like to add to Doctor Palmer's discussion of this very vital problem.

We have preached the importance of dentistry for a good many years, and have caused the number of practitioners to increase from one dentist to every five thousand people in 1907 to one dentist to every eighteen hundred inhabitants in 1933. In spite of this increase in the dental population we know from the information that has been gathered for the year 1929 every dollar spent for medical service only twelve and two-tenths cents was spent for dental care. That is a very significant thing. In addition to that, the profession at the present time probably recognizes or feels that there are too many dentists to meet the needs of the population at present. We say needs, that is all that they ask for; we know that the dental needs of the public are far in excess of their actual demands. We know, too, that the dental population has decreased, that is those who are entering the study of dentistry. For the same period, for instance, between 1910 and 1920 there was an increase of 95 per cent in the number of students attending academic colleges, and by 1930 the number of students in the academic colleges had increased an additional 121 per cent. Now it is significant to notice that between 1920 and 1930 the students in law increased 97 per cent. In theology 86 per cent; in engineering 44 per cent; in mining engineering it shows a decrease of 52 per cent; in pharmacy an increase of 116 per cent, and in medicine 54 per cent. Dentistry is conspicuously among those professions that has shown a decrease.

In the 1922-1923 session there were 1,099 dental students; for the past session of 1933-1934 there were 7,160 students; an increase of approximately 6,000 students in ten years.

The question has been raised as to whether or not, because of death and retirement, the dental profession is being kept

up to its normal standards. We recognize that every change is attended by opposition. The same was true when the public school system was inaugurated. We accept the public schools now as a matter of course. We know, too, that of the hospital beds in this country, more than 62 per cent in 1931 were under government control—more than 62 per cent of the hospital beds in this country were under government control. At the present time we learn that the United States Government has been spending for some several months an average of five million dollars a day for Federal relief. Now my point in mentioning these things is to point out the fact that the American Dental Association, through the Board of Trustees and Committee activities, is alive to these problems.

The Dental Health Survey Committee, in coöperation with the United States Health Service, is conducting and has conducted, as was done in this State, a very worthy enterprise—there may be some feeling, a difference of opinion there, but we know that the personnel of this committee in fostering this idea, have at heart the best interest of the dental profession. And it is hoped that as a result of this survey that a plan will be formulated so that the dental profession may know exactly where it stands on the actual needs, and not on the question of supposition but on the actual needs of the people of this country for dental services, and that a definite plan may be formulated.

Now there is also an economics committee of the American Dental Association which certainly during the past year has been working very effectively. They have divided this committee into five, the five members are divided so that one will represent each section of the country. They have under consideration problems of which Doctor Palmer has so ably presented to you this morning. And their efforts are at your disposal. They will make a report at the meeting in St. Paul, and between now and then those of you who are interested can get in touch with them and get any information you want from this committee. Doctor Palmer has pointed out very pertinently the importance of being slow to study your problems and yet hasty not to lose any time in reaching some decision in this matter. And it is necessary for the individual to review the present problem, and to have regular conferences with the men in his community, because it is by group conferences that we can pool our ideas. Thank you very much. (Applause.)

EDUCATION OF THE CHILD PATIENT TO DENTAL NEEDS

By Marcus R. Smith, D.D.S., State School Dentist, North Carolina State Board of Health

Chairman, fellow members of the North Carolina Dental Society, guests: I will try to talk briefly on the Education of the Child Patient to Dental Needs.

Dentists all agree that the great field for oral hygiene and preventive dentistry is among children, and that the earlier in life a child is impressed with the importance of brushing the teeth twice a day and making periodic visits to the family dentist the greater will be the return in health, in comfort and in appearance. While the efforts of dental and health authorities to impress this idea upon the minds of children through their parents have been very successful, far more satisfactory results are being attained through the coöperation of the public schools of the State.

As a mouth health teacher I contact thousands of children annually. That results can be attained from teaching mouth health to children has been proved to me many times. In one of my locations I found less than 50 per cent of the school children had ever been inside a dental office, and less than 9 per cent were under the regular care of a family dentist. The following year 72 per cent had visited a dental office and 21 per cent were under the regular care of a family dentist. Children are eager to learn and they can be taught. But it must be remembered that the majority of children are taught in the home to fear dentistry. Mother or father has been to see Doctor Blank for the first time in three or four years. The only reason for going was because of pain for several days preceding the visit. Consequently the visit was an unpleasant one for the patient. They never hesitate to discuss the terrible ordeal through which they had to go for correction. But rarely is it explained to the child that it was due to carelessness, neglect and unthoughtfulness on the parent's part that caused this very unpleasant visit to Doctor Blank. The family dentist visits the "Smiths" and meets little four-year-old Mary Smith. Mother makes the introduction by saying, "This is Doctor Blank, he is the doctor that pulls out your teeth." Obviously the child makes its first visit to the dentist with much fear. If the dentist does not have a great love for children and cannot appreciate this little victim's feelings then it is far better for all concerned that the child be referred to one who will understand and who will take the necessary amount of time in teaching the child.

The young patient may easily be trained to look forward to the visit to his dentist with interest, or at least never with any thought of fear. His first visit must be made pleasant, and he must not be freightened at the very beginning of his career of oral hygiene. A nervous child requires an explanation concerning the use of every instrument handled; the fewer instruments used the better the child likes it. I have found that the mouth mirror is a fine instrument as a start, as the patient can find no objection to it or its use.

He may be permitted to hold it in his hand or to look at himself in the little mirror, and then with the aid of a hand mirror in the child's hand the dentist can show him how we count teeth with a mouth mirror and some blunt instrument. I think an explorer is objectionable at this time due to its resemblance to a needle—and the child has heard about that. Other instruments may be introduced with a pleasant explanation of each until a very nervous child may be made to feel very comfortable. Soon an interest will be observed and Doctor Blank should be extremely careful and anxious to answer the little fellow's questions. It, of course, consumes a great deal of time with these explanations, and as the patient becomes interested it is well to dismiss him with a promise that if he will do certain little things for you and return in a few days you will do something for him to make his mouth pretty. This will usually increase his desire to have something done to his teeth.

Inasmuch as you are trying to educate the child it is well not to do any work during the first visit, except perhaps remove a small amount of stain from the front teeth and permit him to look in his mirror and observe the general increase in good looks. All children want to be pretty. If your patient has been properly entertained and he has had a good time during his first visit he will be anxious to return and it should not be difficult to do operative work.

Teaching mouth health in the schools enables me to contact a large number of parents as well as children. It is my opinion that most parents need teaching just as much as the children. In this respect I try to stress the importance of diet, habits, oral hygiene and regular visits to the family dentist on the minds of parents and expectant mothers. We are called upon by civic organizations, parent-teacher associations, high school groups. We have to teach science classes and sometimes even go to prayer meetings as well as many other things in teaching mouth health to children and the public.

Beginning a mouth health program in a school for the first time my first day's work is almost entirely in the nature of getting acquainted in the class rooms, on the playgrounds and in chapel exercises. The lower grades are visited and stories about rabbits, dogs, kittens and other pets are told. When I have gained their confidence plaster models and pictures of teeth are demonstrated with chalk drawings on the blackboard to all the children. It is then explained that I cannot work for everybody due to lack of time. All children are requested to visit their family dentist immediately and get a mouth health certificate. I try to do work for the indigent class, but for obvious reasons this is not explained to the boys and girls. Usually, to stimulate interest, every room that becomes 100 per cent dentally fit by going to the family dentist is rewarded with a half-day holiday for a picnic or party. I usually follow up my programs with periodic letters to the children through their teachers reminding them about the care of their mouths.

A wonderful example of mouth health teaching is exemplified at the Methodist Orphanage in Raleigh. Dr. Arthur Wooten has been teaching those children for five or six years and they all have healthy

mouths. This year there were only five abscessed teeth, all of which were deciduous teeth, among the nearly three hundred children. Three of these were in the mouths of children who had recently entered the institution.

Last summer I had an excellent opportunity to observe many interesting results of work in nutrition under Drs. Percy Howe and Mary Elliott in Massachusetts institutions, particularly Forsyth Infirmary. Returning to North Carolina I selected about twenty rural school children in Currituck County for study, and with the splendid coöperation of Miss Idell Buchan, the county school nurse, we are arresting decay and developing secondary dentin in the mouths of farm children simply by diet. However, I assure you that I am just a student in nutrition.

Much time is given to teaching the children what they should eat and also what they should avoid to have healthy mouths. Once the child becomes interested in his mouth it is easy to get him to follow instructions. Following one of my programs in Currituck County Santa Claus received several letters requesting that no candy be brought as Doctor Smith had told them it was bad for their teeth. When children sacrifice candy they are certainly interested in something about themselves.

Below are some startling facts that should be of interest to every dentist in North Carolina.

A survey of 5,215 children:

Number having tooth brushes	3,987	or	76.4%
Number not having a tooth brush	1,228	or	23.5%
Number brushing teeth regularly	2,174	or	41.6%
Number sharing the family tooth brush	212	or	4%
Number who have ever visited a dental office	2,428	or	46.5%
Number of those who went because of pain only	1,543	or	63.9%
Number under regular care of a family dentist	526	or	1%
Number who have never been inside a dental office	2,820	or	54%
Number grade repeaters in this group			44%

I lectured 112 times while working with this number of children, whose average ages were from 8 to 10 years. Some of these figures were taken from city schools where there were three or more dentists practicing. Let us teach dentistry and let us also give the child patient the attention it rightfully deserves.

(Editor's note: This prepared paper was given before the section on Children's Dentistry.)

President Branch:

Gentlemen, the meeting is now adjourned.

Meeting adjourned at 1:45 o'clock p. m.

SECOND DAY—TUESDAY, JUNE 19, 1934

Meeting of House of Delegates

The House of Delegates was called to order by President Branch at 5:00 o'clock p.m.

A quorum was declared present by the chair and the meeting was open for business.

Dr. B. C. Taylor presented the committee report on the President's Address, as follows; which was unanimously adopted:

REPORT ON PRESIDENT'S ADDRESS

We the Committee on the President's Address beg to submit the following report:

The Committee wishes to commend our President for his enthusiastic efforts to promote and carry to completion the State-wide Mouth Health Survey of school children in North Carolina.

We consider this the greatest step forward made by our profession in years.

We offer praise to his work in bringing new members into our State Society and the reinstatement of former members who had dropped out.

The Committee wishes to memorialize the work of Doctor Branch and the North Carolina State Board of Health for the educational work promoted to lessen degenerative diseases and the comprehensive Mouth Health Hygiene program promoted throughout the State of North Carolina.

The Committee recommends that the members of the North Carolina Dental Society read carefully the President's address as it appears in the Bulletin.

J. H. Wheeler, *Chairman.*
Paul Fitzgerald.
B. C. Taylor.

Dr. J. H. Wheeler, Chairman, Resolutions Committee:

Gentlemen, may I just call your attention to an article that you probably have read in the last issue of the Bulletin. That was a letter that Doctor Johnson transmitted to me relative to a Mr. McCullen. I have that letter right here and will read it to you; also Doctor Johnson's letter:

Kansas City, Missouri, April 23, 1934.

Mr. C. D. McCullen, Claim No. 56263.
Faison, North Carolina.

Dear Mr. McCullen: We have completed the investigation of your claim and we find that you were given first aid by Doctor Davidian on March 18. Following that time you were attended by Dr. J. N. Johnson, dentist.

Our policy provides that for us to have liability, the insured must be attended by a physician or surgeon at least once every seven days. As you had only one date by a medical doctor, we could have liability for only one week of disability.

Such an accident as yours comes under Part IV of the policy which pays at the rate of $100 per month for total disability. Your claim amounts to $23.33 for which our draft is being sent.

Sincerely yours,
C. C. Myers, *Auditor of Claims.*

Goldsboro, N. C., May 18th, 1934.

Dr. John H. Wheeler,
Chairman Liability Insurance Committee,
Greensboro, N. C.

Dear John: I am enclosing a letter under date of April 23rd, from the National Protective Insurance Company, Kansas City, Mo., to Mr. C. D. McCullen, Faison, N. C.

You will note that the National Protective Insurance Company does not rate the Doctor of Dental Surgery a surgeon specializing in the treatment of injuries to the jaws and teeth.

Physicians and surgeons do not make interdental splints—even the laiety is advised of that—and an increasing number of fracture cases are coming directly to the dental surgeon, therefore, I am calling your attention to the clause in the policy of the National Protective Insurance Company, discriminating against the dental surgeon, in order that you may, for publication, give the information to the editor of the Bulletin of the North Carolina Dental Society and to the editor of the *Journal* of the American Dental Association.

Mr. McCullen was injured in an automobile accident March 18th, 9:00 p.m., near the Johnston County Hospital, Smithfield, N. C. where he received first-aid from Doctor Davidian. He was brought to my office at 9:00 a.m. March 19th, bleeding profusely—had been bleeding all night—from a hemorrhage along the line of a fracture in the left maxilla, four teeth were knocked out of their sockets.

Mr. McCullen carried accident insurance in two companies. I filled out both claims for two weeks liability; one of the companies paid the two weeks liability promptly, but the National Protective Insurance Company, because Mr. McCullen was not seen by a physician-surgeon except on the night of the accident is responsible for only a week's liability.

Fraternally yours,
J. N. Johnson, D.D.S., F.A.C.D.

I would suggest that as the article has been published in our local Bulletin that the editor of our Bulletin send a copy of our Bulletin to the American Dental Association and see if they do not want to publish it, too; because this thing ought to be broadcast.

Dr. J. H. Wheeler then read the following resolution, which was unanimously adopted:

Resolved that the North Carolina Dental Society thinks it but fair and proper that the Commercial Dental Laboratories of our State take cognizance of the exact wording of the National Code governing same and think it advisable to quote the same as published in "Code of Fair Competition for the Dental Laboratory Industry," approved on January 22, 1934.

Article VII, paragraph 15, as follows: "Acceptance of Work. No member of this industry shall accept any dental restoration, or adjustment, repair, or processing, except from a dentist or from another dental laboratory.

P. E. Horton.

Dr. J. H. Wheeler:

Now, I have a very voluminous correspondence here. I am submitting this correspondence with the recommendation of the Resolutions Committee that it be laid on the table until at least another annual meeting of the North Carolina Dental Society.

Chicago, June 13, 1934.

Dr. John H. Wheeler,
Box 367, Greensboro, N. C.

Dear Doctor Wheeler: In response to your letter of June 8th, I have transmitted your request for copies of articles now ready for use by dental societies to the Bureau of Public Relations for attention. I think it best, if the Society decides to run these in their local paper to use the heading, "Dentistry and Public Health," as approved by the House of Delegates. These articles are in serial form and probably not always acceptable, but the Bureau is working on other articles which will deal more directly with dental subjects in which the public may be interested. For your information, I enclose copy of letter recently sent to Dr. T. L. Timmerman of Laurens, South Carolina, which is self-explanatory.

As a practical proposition the A. D. A. has been for several years faced with a limited amount of revenue and while the Bureau of Public Relations has been officially authorized as the disseminating point for dental health information, it has not, up to the present time, had sufficient funds for properly functioning. The Resolution introduced in the District of Columbia Dental Society was made for the purpose of drawing the attention of members of the A. D. A. to their own official *Journal*, in order that they might give it substantial and material support. Trade-house journals have flourished through advertising due largely to the fact that they sell their "circulation" to the advertisers, whereas, as a matter of fact probably eighty-five per cent of the business of these advertisers is done through ethical dentists. It would seem logical that some of these vast sums of money spent for advertising in trade-house journals should be diverted to the A. D. A. *Journal*, the money from which can be used legitimately in building up the Bureau of Public Re-

lations, which in turn can carry the gospel of dental health to the public in an ethical manner, as provided for by the plan adopted recently by the House of Delegates. This in turn redounds to the benefit of the dentist and the manufacturer, and completes the "beneficial circle." The plan was developed by Mr. Claridge, the business manager of the A. D. A. and my Committee of the Board of Trustees is endeavoring to give him all possible support. The resolution referred to has already been adopted by probably a dozen dental societies, and here in the District of Columbia on each of our meeting notices we carry the following notation, "Whenever possible, use the American Dental *Journal* as your Buyer's Guide, and tell your dealer." It is having a very practical effect and last information from Claridge is to the effect that *Journal* advertising has increased twenty-five per cent.

I trust that this will give you the information you desire, and that North Carolina may help the cause along by the passage of this resolution or a similar one.

Certainly enjoyed being with you last year, and especially so because it seems like "home" to be in the old North State. I think it very probable that Willard, Jr., will begin his medical course at Duke next fall.

Sincerely yours,

C. Willard Camalier.

June 5, 1934.

Dr. T. L. Timmerman,
Laurens, S. C.

Dear Doctor Timmerman: In further response to your letter of May 28th, concerning a resolution you desire to propose to the South Carolina Dental Association, I beg to inform you as follows:

The Committee of the Board of Trustees, of which I am chairman, was created for the purpose of outlining a plan for the dental education of the public which would be effective and at the same time in accordance with the ethics of the American Dental Association. This, I believe was accomplished quite successfully at the Seventy-fifth Annual Session of the Association held at Chicago, Illinois, August 7th to 12th, 1933 (see page 310 of Transactions). Briefly, it contemplates that all educational publicity of the American Dental Association shall be centered in the Bureau of Public Relations, that all material of this character used by the Association and its component societies shall be prepared or secured by the Bureau, have the approval of the Committee on Dental Education and the United States Public Health Service. You can readily see the safeguard thrown around the whole situation which otherwise might get out of bounds as was the case heretofore.

It has never been the intention of this Committee nor of the Bureau of Public Relations to attempt to regulate State programs because it is believed that the good judgment of the dental societies in the various communities can be better depended upon to handle their local problems. However, with the example set by the National

organization it is felt that no difficulty will be experienced in each State developing an effective ethical program. If a State association desires to promote educational publicity, the material of the Bureau of Public Relations is available and can be presented to the public without any dentist feeling under the necessity of apologizing to his friends or patients—the approval of the American Dental Association and the United States Public Health Service being all that is necessary to offset any such feeling. At the present time, there is a great deal of material in the Bureau which can be used by dental societies—newspaper articles of one type (others being prepared), the booklet "Care of the Teeth," first grade pamphlets, etc., and the radio talks on their way to completion. I think I can assure you that by fall there will be sufficient material available to meet the requirements; this will be added to constantly and within a short time there should be sufficient on hand to meet every purpose.

It would seem, therefore, that if South Carolina decides to follow the general plan of educational publicity as approved by the House of Delegates, there could not be any possible objection from the National standpoint. However, it would surprise you to know the difference of opinion on the subject—some localities want plenty and others no publicity—so it would seem that a State should use its own prerogative of self-government and decide for itself, using the national plan for its guide. If radicals should secure control in any local situation, and there was a complaint, the matter could be referred to the Judicial Council for adjudication, but I cannot now foresee any such situation developing.

All material, as far as possible, should be approved as specified in the A. D. A. plan, but in the event that the material in the Bureau of Public Relations is insufficient for the need, other data should be prepared by the South Carolina Dental Society, a committee from that organization to be appointed for this purpose. Personally, I do not think it a good plan for individuals to undertake a publicity campaign unless specifically authorized to do so. Of course, every dentist in his own community has the right to speak to public or private gatherings on matters of health but I think it best to obtain authority from his society and that the publicity material used be sponsored by groups or associations in order that no ulterior motive may be suspected.

The Bureau of Public Relations obviously does not have the time nor the authority to pass on all articles submitted by individuals or component societies. In order that a publicity article may receive the approval of the American Dental Association, it is necessary that it be approved by the Bureau, the Committee in Dental Health Education, and the United States Public Health Service. Naturally, this takes time but when complete, it is most kindly received by the public. This particular feature may seem like "red tape" to you but with such a large organization to deal with, it is vitally necessary to safeguard it in many ways. Therefore, if the exact material is not available from the A. D. A. when you need it, a committee of your State Society should be appointed to prepare and pass on other material.

I trust I have made myself clear on this situation and while I do not feel I should phrase your resolution because my committee and myself might be accused of promoting publicity rather than guiding it, believe you have sufficient data in hand from this letter to assure you that you are on the right track provided all authority for your campaigns in South Carolina is in the hands of the State and component societies. If I can be of further assistance do not hesitate to command.

Very sincerely yours,
Chairman, Committee on Education
Publicity, Board of Trustees.

LAY EDUCATIONAL MATERIAL

Will be developed under the "Beneficial Circle" plan as fast as the facilities and support of the plan permit. This material will be of an ethical and interesting nature. Much of it will go out to the public under the approval of the United States Public Health Service as well as the American Dental Association.

The following program is contemplated at the present time:

1. *"Care of the Teeth" Booklet.
2. *First Grade Educational Material.
3. *Newspaper Articles.
4. Radio Talks.
5. National Radio Broadcasts.
6. *Motion Pictures:
   (a) "Nature-Builder of Teeth."
   (b) "A Life of a Healthy Child."
7. Lay Education Exhibit Material.
8. "Thumb-Flip Movie" on Toothbrushing.
9. Sixth to Eighth Grade Educational Material.

*Already available.

Do your part by using and recommending products advertised in *The Journal*, as increased advertising revenue will be used to develop this program.

Raleigh, N. C., June 5, 1934.

Dr. John H. Wheeler,
Greensboro, N. C.

My dear Doctor John: I am sending to you as chairman of the Resolutions Committee a letter and resolution from the District of Columbia Dental Society, for whatever attention you may see fit to give this subject.

Looking forward to seeing you in Wilmington. Every good wish, I am,

Sincerely yours,

FRED.

District of Columbia Dental Society

Washington, D. C.

Dear Doctor: There is transmitted, herewith, copy of resolutions introduced by Dr. C. Willard Camalier, passed on April 10th, 1934, by the District of Columbia Dental Society, and it is felt that if some similar action could be taken throughout the country, it would be of benefit to the *Journal*, as well as dentistry in general.

A reprint of a page from the *Journal* has been mailed to each member of the District of Columbia Dental Society and a copy of same is enclosed with this letter.

An expression of the reaction of your society to this proposition would be greatly appreciated.

Fraternally yours,

W. M. Simkins, *Secretary-Treasurer.*

District of Columbia Dental Society

Washington, D. C.

The following resolutions were introduced by Dr. C. Willard Camalier, at a meeting of the Society held April 10th, and approved by unanimous vote.

Whereas, the *Journal* of the American Dental Association is the official organ of the association and organized dentistry;

Whereas, the advertising policy of the *Journal* is conducted on the highest standard for the benefit and protection of the dental profession and the public;

Whereas, the said *Journal* deserves the whole-hearted and substantial support of every member of organized dentistry; and

Whereas, the Beneficial Circle Plan was created for the purpose of stimulating interest in and obtaining further financial support for the *Journal*, having as its ultimate aim, the procurement of additional funds through the sale of legitimate advertising space, to be used for the dental education of the public through the Bureau of Public Relations;

Be it Resolved, that the District of Columbia Dental Society urges its membership to consistently support the *Journal* in every way, and use and recommend the products of those firms advertising in the *Journal;*

Be It Further Resolved, that the Society records its approval of the Beneficial Circle Plan; and

Be It Further Resolved, that copies of the resolution be forwarded to the officers and trustees of the American Dental Association, the secretaries of state and component dental associations, state society bulletins, and all journal advertisers.

The report of the Resolutions Committee was unanimously approved and received.

Dr. J. H. Wheeler, Chairman of the Resolutions Committee, offered the following resolutions, which were unanimously adopted:

Resolved, that the North Carolina Dental Society wishes to go on record as heartily endorsing the entire program of Mouth Health Education as now being conducted by the State Board of Health; and organized dentistry in North Carolina wishes to go on record as appreciating the coöperation of the State Board of Health in assisting in the successful Mouth Health Survey unselfishly conducted by the members of this organization.

The survey has shown a startling need of even greater activity in Mouth Health Education and this society pledges its whole-hearted coöperation in support of such enlarged program as the State Board of Health is financially able to support and foster.

Inasmuch as the Mouth Health program in this State is receiving nation-wide admiration and attention, we must not turn back but rather go forward.

We wish to thank Dr. J. N. Johnson, dental member of the State Board of Health, for his untiring activity, in his official capacity, who has given generously of his time; and to ask the secretary of this society to send a telegram to Dr. J. M. Parrott, Secretary of the State Board of Health, at his home in Kinston, expressing our appreciation for his coöperation and wishing for him a speedy recovery.

Be it Resolved, that each Chairman of the County Health Board express to their respective school superintendents and principals their appreciation for their whole-hearted coöperation in the recent Mouth Health Survey.

Dr. J. Martin Fleming, of Raleigh, N. C., offered the following resolution:

Whereas, the North Carolina Dental Society has for several years strongly supported non-proprietary Dental Journals and has demonstrated its active support of the cause by the adoption of earlier resolutions and by the Society establishing its own BULLETIN; and

Whereas, the North Carolina Dental Society is desirous of contributing to the efforts being made to eliminate private profit journals from dentistry;

Therefore be it Resolved, that the North Carolina Dental Society do not release for publication in trade-house journals or other private profit periodicals any of the papers which appear on our programs;

Be it Further Resolved, that the Society disapprove of its members contributing literature to private profit dental journals.

Be it Further Resolved, that copies of this resolution be sent to the Secretary of all State Societies, Deans of all Dental Schools, editors of all non-proprietary journals, and to the Commissioner on Journalism of the American College of Dentistry.

After considerable discussion, it was moved and seconded that the resolution be tabled. The motion was put and lost.

Dr. J. Martin Fleming, moved that the resolution as offered be amended so as not to apply to "those magazines for which we pay." This amendment was accepted and unanimously adopted.

The resolution as offered, with the amendment as adopted, was then put and unanimously adopted.

Dr. J. Martin Fleming submitted the following resolution, which was unanimously adopted, a copy to be sent to the North Carolina Medical Society:

REPORT OF COMMITTEE ON RELATIONS OF PHYSICIANS AND DENTISTS

The Committee on "Relations of Physicians and Dentists" reports that the Medical Society, through its Secretary, Doctor McBrayer, informed our Secretary, Doctor Pridgen, just shortly before the Medical Meeting that they would have room on their program for only one dental paper. We had arranged for two and had also invited two of their members to appear on our program, which was in accordance with our original agreement of two men from each Society and this is the first break that has come in that agreement.

The Committee recommends that, inasmuch as our program is as full as theirs, we invite only one member from the Medical Society to present a paper to our Society each year. We have felt that the original agreement was, and would continue to be, mutually helpful but we have no desire to make it a one-sided arrangement nor to attempt to force ourselves on their programs.

If they do not care to continue the original agreement, or if they wish to discontinue it altogether, your Committee recommends that we acquiesce in the same spirit of good will in which we first began it, a hope of mutual advancement and understanding.

J. Martin Fleming.

Dr. J. Martin Fleming:

I haven't written this and I will just ask that it be taken down into the record as the report of the Dental Relief Committee. I asked last year that you designate some depository for that money and the Wachovia Bank in Raleigh was named, and the fund is there, amounting to thirteen hundred and thirty-eight dollars and some cents, not counting this year's contribution, which hasn't come in yet. We have had one or two applications for distribution of that fund, but when we investigated we found that it wasn't quite a case for the beginning of the distribution of the fund. So the fund is now intact in the

Wachovia Bank at the order of the Executive Committee of the State Dental Society.

It was moved by Dr. Wilbert Jackson that the report be received, which was seconded and unanimously carried.

Dr. J. Martin Fleming:

Mr. President, I am Chairman of the Committee on Dental Ethics. I am happy to report that no case of violation of the Code of Dental Ethics has been reported to the committee this year.

It was moved that the report be received. Motion seconded and unanimously carried.

Dr. D. L. Pridgen made the following report for the Exhibit Committee, which was unanimously adopted:

Your Exhibit Committee wishes to submit the following report:

Amount of space sold	$426.00
Collected to date	165.00

We expect to collect the balance within a few days.

D. L. Pridgen, *Chairman.*

The Secretary-Treasurer made the following financial report, which was unanimously adopted; permission being granted to substitute the audited financial report for the one adopted:

GREATHOUSE & BUTLER

Certified Public Accountants

Rocky Mount, N. C., August 15, 1934.

To the Officers of North Carolina Dental Society:

Gentlemen:—We have audited the recorded transactions of D. L. Pridgen, D.D.S., Fayetteville, North Carolina, Secretary-Treasurer of the North Carolina Dental Society, for the period from July 20, 1933, to August 4, 1934, and as a result thereof we submit herewith our report, consisting of the following described statements:

Exhibit A—Statement of Receipts and Disbursements for the period from July 20, 1933, to August 4, 1934.

Schedule 1—Reconciliation of Account with the Branch Banking and Trust Company, Fayetteville, North Carolina, August 4, 1934.

All receipts of record were audited by us and were found to have been properly accounted for.

Disbursements were audited in detail and all were found to be supported by properly signed vouchers and miscellaneous disbursements were further supported by invoices and other data.

District Secretaries from the Second, Third and Fifth Districts reported their collections to the chairman of the Executive Committee. No reports were received from the Secretaries of the First and Fourth Districts. Confirmation of collections made by district secretaries by reports direct to the chairman of the Executive Committee enables the Auditor employed to make a more comprehensive report, and the district secretaries making these reports are to be commended.

The records of the Secretary-Treasurer were found to be in excellent condition and he is to be commended for the neatness and accuracy of his records.

Respectfully submitted,

GREATHOUSE & BUTLER,
Certified Public Accountants.

NORTH CAROLINA DENTAL SOCIETY

D. L. PRIDGEN, D.D.S., FAYETTEVILLE, N. C., SECRETARY-TREASURER

STATEMENT OF RECEIPTS AND DISBURSEMENTS

For the Period from July 20, 1933, to August 4, 1934

EXHIBIT A

Receipts

District Receipts—Membership Dues:	*Annual*	*Life Members*	
First District	$1,017.00	$ 12.00	$1,029.00
Second District	1,204.00	36.00	1,240.00
Third District	803.00	44.00	847.00
Fourth District	772.00	32.00	804.00
Fifth District	821.00	36.00	857.00
	$4,617.00	$ 160.00	
Total District Receipts			$4,777.00
Miscellaneous Receipts:			
Sale of Exhibit Space		$ 396.00	
Sale of Banquet Tickets		208.00	
Interest on Savings Account		49.55	
			653.55
Total Receipts			$5,430.55
Balance—July 20, 1933			2,408.32
Total Receipts and Balance			$7,838.87

Disbursements

American Dental Association:		
Proportionate Part of Dues from Members:		
Annual Dues	$1,604.00	
Life Members	156.00	
		$1,760.00

Expenses:		
Salary—Secretary-Treasurer	$150.00	
Salary—Editor Publisher	150.00	
Expenses—District Secretaries	125.00	
Telephone and Telegraph	24.69	
Printing 1933 Proceedings	679.75	
North Carolina Dental Relief Fund	200.00	
Honoraria and Expense of Essayists	635.00	
Banquet and Entertainment Expense	310.88	
Publicity Committee Expense	33.10	
Stationery, Printing and Supplies	148.84	
Floral Designs—Deceased Members	20.93	
Secretarial Work—Wilmington	25.00	
Mimeographing	6.65	
Premium—Bond of Secretary-Treasurer	7.50	
Premium—Bond of District Secretaries	25.00	
Postage	48.41	
Floor Plans—Exhibit Space	3.00	
Federal Check Tax	2.04	
Protest Fees	1.50	
Reporting 1933 Convention	150.00	
Reporting 1934 Convention	129.00	
Auditing	15.00	
Mouth Health Survey—Postage	100.00	
Dance Tickets for Guests	10.40	
Rental of Adding Machines	2.50	
		$3,004.19
Total Disbursements		$4,764.19
Balance, August 4, 1934, on Deposit, Branch Banking and Trust Company, Fayetteville, North Carolina:		
Checking Account	$1,010.13	
Savings Account	2,064.55	
		3,074.68
Total Disbursements and Balance		$7,838.87

North Carolina Dental Society

D. L. Pridgen, D.D.S., Fayetteville, N. C., Secretary-Treasurer

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RECONCILIATION OF BANK BALANCE, AUGUST 4, 1934

Schedule 1

Balance as Per Bank Statement:		
Branch Banking and Trust Company, Fayetteville, N. C.:		
Checking Account, July 27, 1934		$1,214.89
Additions:		
Deposits not credited at Bank, August 4, 1934		40.00
		$1,254.89

Deductions:		
Checks Outstanding—Dated:		
July 25, 1934—No. 190	$ 28.76	
July 27, 1934—No. 192	8.00	
Aug. 4, 1934—No. 193	8.00	
Aug. 4, 1934—No. 194	200.00	
		$ 244.76
Total Checking Account		$1,010.13
Savings Account		2,064.55
Total—See Exhibit A		$3,074.68

Dr. Paul Fitzgerald, Chairman of the Oral Hygiene Committee, made the following report, which was unanimously adopetd:

The Committee on Oral Hygiene beg to submit the following report:

During the year 1934 a Mouth Health Survey was conducted in the public schools of North Carolina. In the State as a whole two hundred and thirty-five thousand three hundred and seventeen children were inspected.

Thirty-seven thousand three hundred and nineteen needed no dental treatment. One hundred and thirty thousand three hundred and eighty-five children had never visited a dentist. Thirty-seven thousand and twenty-four permanent teeth needed extraction and one hundred and seventy-four thousand two hundred and forty-four permanent teeth needed filling.

Twenty-one thousand one hundred and three children had diseased gums.

The Committee extends praise and commendation to Dr. E. A. Branch for his untiring work during the past year.

The Committee also wishes to thank the members of the North Carolina Dental Society who, by their hearty coöperation, made this report possible.

Paul Fitzgerald, *Chairman.*
B. C. Taylor,
C. C. Bennett,
A. Pitt Beam,
Neal Sheffield.

It was moved, seconded, and unanimously carried, that the Secretary be allowed to discontinue sending out certificates of membership.

The House of Delegates then, at 6:30 o'clock p.m., adjourned.

SECOND DAY—TUESDAY, JUNE 19, 1934

Annual Banquet

The annual banquet was called to order by President Branch at 6:30 o'clock p.m.

Invocation was given by Rev. A. T. Brantley, Pastor, Trinity Methodist Church.

President Branch:

Ladies and gentlemen: I want at this time to introduce to you Mr. Ray Funderburk. Mr. Funderburk is Superintendent of the New Hanover County schools and toastmaster tonight. Toastmaster Funderburk. (Applause.)

Toastmaster:

Mr. President, while we are finishing our eating we will be entertained by some of the members of the Eric Peterson Orchestra.

Toastmaster:

Ladies and gentlemen: I am mighty glad to be associated with you here tonight as a school man, because you are trying to do the same sort of work that the school people are trying to do. Several years ago it was a horrible thing to think of going to the office of the dentist because we thought of pulling teeth and of gouging and boring and doing all those things that gave us mental and physical agony, but not so today; you people are trying to teach the public something, trying to teach them how to do. But, gentlemen, you are doing just what the teachers have been doing; you are trying to work yourself out of a job.

I hope, gentlemen of the dental profession in North Carolina, that the time will soon come when we will not have so many jackasses holding offices in North Carolina and that you people will have an opportunity to get an audience of the people of North Carolina and there obtain appropriations to do that which you are trying to do, and that is to have every boy and every girl in this commonwealth of ours to have an opportunity of a healthy mouth, good teeth, so that he may be a contributing citizen to the State. (Applause.)

So, gentlemen, I bid you God speed in the work that you are trying to do with the young boys and girls of North Carolina to make them strong and healthy. (Applause.)

At this time I recognize Dr. J. Martin Fleming of Raleigh. Doctor Fleming. (Applause.) Stand up and make yourself known. (Applause.)

Doctor Fleming:

Mr. Toastmaster, a very pleasant task has been assigned to me, and that is the presentation of a past-master emblem to one of my Raleigh dental practitioners, one of my brother practitioners. I might go on and on, recounting the virtues of this man, but it might only embarrass him. Last year at Chapel Hill Dr. John Swain, in nominating one of his fellow townsmen for one of the offices, paid one of the most heart-felt tributes I have ever heard paid any man in this Society. He simply said that he had practiced in the same building with him for a period of some years and knew his worth. He said that and nothing more. To me has been given this same privilege of practicing for twenty years with my brother and it has given me a chance to know him. And I, like Doctor Swain, want to pay him that simple tribute of saying that I know him well. And so, in behalf of some of his intimate friends and on the principle that a fair exchange is no robbery, he having presented me at such a banquet last year, it gives me pleasure to present at this time Past-President S. Robert Horton, my friend and neighbor. (Applause.)

Dr. S. Robert Horton:

Ladies and gentlemen, I want to assure of my appreciation to all of you. I want to assure you that I appreciate this emblem that has been presented to me. Whenever I look at it I will think of my special friends who donated it, which has been so graciously presented by my friend and fellow practitioner, Dr. J. Martin Fleming of Raleigh. So long as I am capable of controlling and being conscious of my sentiments and feelings, I shall always hold this very dear and remember many of your faces throughout life. Thank you. (Applause.)

Toastmaster:

I recognize John A. McClung of Winston-Salem. (Applause.)

Doctor McClung:

Mr. Toastmaster, friends of our society, members and friends: I deem it a distinguished honor and privilege to present the past-president emblem to one of our beloved and most faithful members. This gentleman for many years has taken an active part in organized dentistry and in the work of this society, having served as president and heading many important committees through the period of years. Surely, most of you must know him. In this connection I believe his attendance record is most unusual; I doubt seriously if any member of this society has attained this wonderful record. When I tell you that this member has attended forty-one consecutive annual meetings, I hope it will give you the thrill that it gave me when I learned of the fact. He is a polished gentleman, highly respected, and a good worker in the church and community. Not only has he served as president of this organization, but he is also a past-president of the Kiwanis Club and he served for many years on the city council board. I will ask P. E. Horton to rise. I present you this emblem of a past-president with the love and affections of the profession. (Applause.)

Dr. P. E. Horton:

Ladies and gentlemen: I want to say that I deeply appreciate this emblem and I hope to attend many more than forty-one of such meetings as this one. (Applause.)

Toastmaster:

I wish to recognize Dr. H. C. Carr, of Durham.

Dr. Henry C. Carr:

Mr. toastmaster, ladies and gentlemen: It has been assigned to me the pleasant task of presenting an emblem to one of our beloved members and I would like to say right here that I don't believe that there is a man in our profession of the North Carolina Dental Society that is loved and admired by all as much as the man to whom this emblem goes. He is past-president of the North Carolina Dental Society. He served firmly and faithfully on the Examining Board for twenty years. Some of you might get the idea that this is an old man, but you are mistaken. Some of the younger men have played golf with him and they say he is still young. I will ask Dr. J. S. Spurgeon, of Hillsboro to stand up. (Applause; much applause.)

Doctor Spurgeon has served with credit and honor in every post to be given by the North Carolina Dental Society and in the Durham County Dental Society and he has done his work without hope of publicity or any fuss to be made over it. And, Doctor Spurgeon, in presenting you this medal I want to say to you that it carries with it the love and esteem of every man in the North Carolina Dental Society, and when you wear it, I hope that you will wear it with great honor to yourself and to the society. (Applause.) All stand. (Much more applause.)

Dr. J. S. Spurgeon:

Friends and ladies: This honor has come to me so unexpectedly that I fail to find words to express my appreciation for another token of friendliness, friends whom I am anxious to serve. I thank you. (Applause.)

Toastmaster:

Is Dr. F. L. Hunt, of Asheville present, let him stand up and let us take a look at him. (Applause.)

Dr. F. L. Hunt:

Mr. Toastmaster, ladies and gentlemen: Twenty years ago, at my own insistence, I had the pleasure of placing in nomination for the office of President of the North Carolina Dental Society, one of my fellow townsmen. He and I started out at about the same time and during all of these years, during all of that time of about thirty-three or forty-four years, I have practiced in the same town with him and I have found him one of the finest fellows and a man thoroughly devoted to his profession, a skillful practitioner, a splendid diagnostician, and an all-round good fellow. And when you can say that of a man who is practicing in your own town you are able to say a good deal these days. (Applause.) I have very great and extreme pleasure in presenting to this man the emblem of the past-president. Dr. J. A. Sinclair. (Applause.)

Dr. J. A. Sinclair:

Toastmaster, ladies and gentlemen: I thank you from the bottom of my heart. (Applause.)

Toastmaster:

Dr. J. N. Johnson, of Goldsboro. (Applause.)

Dr. J. N. Johnson:

Mr. Toastmaster, ladies and gentlemen: I have about lost my voice drinking this Cape Fear water down here. (Laughter.) I also have the pleasure of presenting a past-president emblem to a young man in years and ideals. It gives me great pleasure to present this emblem to Dr. E. B. Howle. (Applause.)

Dr. E. B. Howle:

Mr. Toastmaster and Doctor Johnson: I do wish to say that this is an unexpected pleasure, but one which carries with it my—Oh hell, what is the use! (Much applause; much laughter and applause.)

Toastmaster:

Good! (Much more applause.)

Toastmaster:

At this time, ladies and gentlemen, we will have a presentation of the president emblem to the retiring president, and I recognize Dr. J. S. Betts, of Greensboro. (Applause.)

Dr. J. S. Betts:

Toastmaster, ladies and gentlemen: During the early years of one's life, in the late teens, when one is following his ideals in life, impressions frequently come to him that stay with him during life. It was my high privilege, as I go back over the track of the years to the time when I entered college at old Trinity (now Duke University), to sit at the feet of a certain gentleman who taught Latin. And ever now and then he would depart from the text and quote something from another Book. And I can ever remember his reference to one of the old prophets, Michael: "And what does God require of thee but to do justly, love mercy, and walk humbly before thy God." I am not a minister, but I wish to enlarge upon that text from the mouth of the old prophet. To do justly, you have got to be kindly disposed; to live up-rightly, you have got to be kindly disposed; to love mercy, you have got to expect mercy from your associations and you have got to extend mercy. You must see the good in those about you, not try to show them how, not try to make them live according to your standards, but show them how to live. That old gentleman has gone to his reward long ago.

In thinking of what I am going to say to our president that is retiring, he is really gifted in seeing the best in his fellow man and his associates. And he is always ready with a word of encouragement for a man who does his best and leaves the rest. I got a text from our speaker of the morning when he said humanity is divided into three classes; one class are actors, persons who make things happen; the second class are those who watch it happen; and the third class are those that don't know what has happened. I put our retiring president in the first class; he makes things happen. I don't have to argue that to this audience, not at all.

It gives me great pleasure to present to you, Doctor Branch, the retired president emblem, something that is to be prized. And when your faithful wife and your precious daughters look upon this emblem they can remember that it represents the profession, the high regard, the esteem of every member of the North Carolina Dental Society. (Applause.)

Dr. Ernest A. Branch:

Mr. Toastmaster, Doctor Betts, and friends: Of course, I knew this was going to happen and I had a speech—but somehow another Doctor Joe has knocked it out. I just thank you. I turn this over to "Miss Emma." (Applause.)

Toastmaster:

The president and those who are responsible for the program this evening in looking about for somebody to make the main speech of the evening, did not select one of their own profession; perhaps they selected someone who wiggled around in a chair of the dentist. And we are to hear from the other side of the desk this evening and it is with peculiar pleasure that they selected the Executive Secretary of the University of North Carolina. We are happy to have with us Mr. R. B. House. (Much applause.)

Mr. R. B. House:

Mr. Toastmaster, ladies and gentlemen: I have been formally warned of the passage of time. Nevertheless, we are a hardy race and we can stand speeches and I want you to understand that I am the speaker of the evening. (Laughter.) I was told that we were going to begin supper at 6:30 and that the meeting was supposed to end at 9:30. I observed that they began supper at 7:30 and so I have one hour at my disposal. (Laughter.)

If you observe any sadness or sternness about my countenance, it arises from my function. In the early days, one of the great Roman emperors resolved to give his constituency a treat and let them see a Christian thrown to the lions. So he got a little "weasley" Christian and a little weakened lion. He put the Christian in the arena and turned the lion loose. The lion, in a weakened way, roared up to the Christian, but the Christian leaned over and whispered in the lion's ear. The lion tucked his tail and ran back to his den. The emperor said: "This will never do; send in a larger lion." So the attendants sent out a middle-sized lion, and he roared up to the Christian; but the Christian whispered in his ear and he tucked his tail and rushed back to his den. The emperor said, "Send on the biggest lion." And so they sent out a large, roaring black lion and this fierce-looking lion roared up to the Christian, but the Christian whispered in his ear and he tucked his tail and ran back to his den. The emperor sent for the Christian; he said, "How is it that you are able to upset the plans of my festival and the courage of my lions? What is it that you have been saying to my lions?" The Christian said, "Your Majesty, I said 'immediately after eating you will be expected to say a few words.'" (Laughter.)

An after-dinner speaker has two functions to perform; one is to say something under the name of humor and he usually gets up a lot of anecdotes—and I hereby define an anecdote as something stale that needs airing (laughter); and he is also supposed to say something sensible and to make that very brief.

I think it is a great privilege that you have allowed me, to come to Wilmington and gather with you and to bring you the greetings of your last year's host, the University of North Carolina. We still remember your good fellowship, your friendly spirit, and we hope that you will come to us again. We are with you and your purposes and we believe in you and I want to congratulate you on showing for the first time this year a meeting that makes a room at a premium in a North Carolina hotel. But we shouldn't be surprised at that; everybody knew that the dentists had tremendous drawing power. (Laughter.) In fact, my friends, you fill places in our lives that no others can fill. (Laughter.) And in a world that has been paralyzed of late, its businesses and professions, you have still been plugging away. (Laughter.) And you offer an encouragement to a world that has gone over-mad about inflation, in that through all the years of monetary excitement you have held rigidly to the gold standard in your work. (Laughter.) And I think the greatest sign of faith that I know of is that of the dentists of North Carolina who resolutely preserve the teeth of our citizens even though they are not quite sure that we will ever have anything to chew again. (Laughter.) That is humor. (Much laughter.)

Now bear in mind that I have left the humorous part of my speech altogether now and we have moved into the inspirational side.

So many years ago that we can't possibly place the date of it and in a war in which we have altogether forgotten the issue, the Greeks fought the Trojans for ten years and destroyed their city. Now a great poet made that event live forever through his imagination,

because he interpreted that war in terms of the beauty of Hellen, so beautiful that both sides said they would willingly die for her. Now, because a great poet took a relatively insignificant event and made it live forever, why we lesser people have ever since been trying to go behind the scenes and say what really was the cause of the war between the Greeks and the Trojans. We try to put it in new terms of politics, of commerce, of trade, but the majesty of that thing mocks us forever and the great poet seems to say to us, "There is a picture of life; in time, all of your practical affairs that you are so hot about will be forgotten and the only thing about your lives that is going to live is going to be the ideal of beauty for which you strive, the courage with which you go about your work, the manner in which you associate with others and the wisdom and the encouragement with which you do your work."

And I wanted, therefore, to talk about the influence of this thing that we call imagination on these hard-boiled practitioners of our day and generation. The great general, Napoleon, who sent men to death willingly for those purposes and who knew what he was doing said, "Men live not by practical desires but by imagination." And a greater than Napoleon said that, "Men live not only by one word but by every word that proceedeth out of the mouth of God." Now, we think we are up against practical issues all the time; we think, in this generation, we are up against the greatest practical issue that ever existed. But we are not having any harder times than people had in the first days and generations. The point I want to drive home is, that thought precedes action and if we don't raise the quality of our thinking, we are not going to do much with our actions. And imagination precedes thought; it is the first step in thought. You know, I think the most practical lesson that could be taught to our hard-boiled so-called men and women of this generation in business, is that Jesus of Nazareth was a good business man and a thinker. He had something to say about that; the primary law of business success you will find in the Bible; it is simply this: "Seek ye first the kingdom of God and its richness and then these other things will be added." Now that sounds like a congregational sermon and I mean it to sound that way; but I want to say something about that reward. You don't get reward of business as a child gets sticks of candy; not at all. You get your reward because you have put first things first and then your life is enriched in the natural order of your thinking and acting.

Now let's take a look at business America, just for a moment. We pride ourselves on being practical business men; we have aspired to all sorts of things and we have achieved magnificently, I think, in many fields—and I do not have time to illustrate what I mean by that. But what we want the world to know and what we tell ourselves and want to be clearly understood is that we are business men, business with a big "B," that we can set the pace in all fields. And so we say we can set the pace in the field of religion, and we have always patronized religion, we have always used it to decorate our respectability, but we never have yielded to it as something to control our thought and our action.

We have written a magnificent chapter in government, but we have always considered the government primarily a handmaid of business. It is the same in education. We have written great chapters in education, but it is all a preparation for success in business. And culture—big words. Our chief aim is to succeed in business, and to succeed in business has meant primarily to make money. Money is a good thing; but what I am trying to say now is, that it is a specializing thing.

For four hundred years the white man, coming out from Europe, following Columbus, and going into the uppermost parts of the earth, has been engaged in one thing, he has gained three-fourths of the inhabitable globe. We have been engaged in the colossal scramble for free land and now that is gone. And a lot of things that we have thought were business successes have been nothing but the accident of time and place. Granting everything to our character and generation, nevertheless, we have simply come to a change in the fundamental basis of our American living. For four hundred years the European white man, our people, have been blessed far beyond the average of humanity with material things. Now we are simply coming back a little closer to that standard human problem that runs through all the ages and that has given food, clothing, shelter, and none of us are going to starve to death. How much can your imagination and your spirit contribute to make your life an interesting and wholesome thing on this earth. And that is what we are scared to death of; that is where we are balking. Our boys and girls coming up through school and college have kept all the business rules, they have arisen early and worked late and done everything else that they have been told. Now they have got nowhere to go and we know that they and others like them are not going to go into jobs until new jobs are created. And their new jobs are not going to be created until the imagination of our people find new things to do and until the social and cultural imagination of our people make those new jobs interesting and respectable.

We have side-tracked music in America. If you don't believe it, try to get anyone to sing! They think it looks silly. Art is the same way. If the average person should start out and try to paint, they would lock them up to try to save his soul. Humor—we are talking about that! Do you know what nine-tenths of American humor is? Nothing on earth but retelling stale jokes, which were gotten out professionally in the first place. There is no humor in them at all. We are all confused. You take amusement in America; the average American's idea of amusement is with a crowd of people, sitting down, and with some professional person to entertain them, with nothing for him to do but simply sit in concert and listen.

My message to you is that it is better to buy a fifty cents mouth harp and learn to play it yourself than to pretend about something you don't know a thing in the world about.

Now it is in just those fields that we are barren and hungry and don't know how to get food; but when we do, when we awaken and balance up that side of our lives out of imagination and thinking, then will come resources for the enrichment and the enlargement of our lives. There isn't but one thing that is more fundamental than

that, and I began with that, and that is religion. We are paralyzed without this religious ability. But, when we get this spiritual ability along with the resources of thought and imagination, then I think, and then only, will America move forward into the full bodily life that we really deserve. (Applause.)

Toastmaster:

I wish to state that the dentists will now go into their business meeting but as far as we are concerned the banquet is at an end.

The annual banquet then, at 9:15 o'clock p.m. adjourned.

SECOND DAY—TUESDAY, JUNE 19, 1934

Evening Session

President Branch called the meeting to order at 8:30 o'clock, p.m.

President Branch:

Gentlemen, I am going to ask that we come to order.

Gentlemen, we are gathered together at this time for the purpose of electing officers. The first is the president-elect of this Society. Whom will you have?

Dr. J. Martin Fleming:

Mr. President: It has been my misfortune on many occasions to nominate for election to the high office in this Society men who for some reason have gone down into defeat. It is my privilege to nominate a man whom I think you will elect unanimously, but in saying that I am not trying to cut off any other candidates. But it is my privilege to nominate a man who has served faithfully almost every committee in the Society and anybody that knows him or ever associated with him knows that he does his work well. He is fitted handsomely for anything we put upon him.

Therefore, it gives me pleasure to nominate for that position, Dr. Z. L. Edwards, of Washington, North Carolina. (Applause.)

Dr. A. T. Jennette:

Mr. President, it really gives me a great deal of pleasure to be able to second the nomination of a man whom I always

considered to be one of my best friends and along with that one of the best practitioners I know of. It really is with a great deal of pleasure that I second the nomination of Dr. Z. L. Edwards, of Washington, North Carolina. (Applause.)

Dr. George C. Hull, of Charlotte:

May I have the pleasure, Mr. President, of moving that the nominations be closed and that the Secretary cast the ballot for Doctor Edwards unanimously? (Applause.)

The motion was seconded and unanimously carried.

The Secretary cast the unanimous vote of the meeting and Dr. Z. L. Edwards is declared duly elected as President-Elect of the North Carolina Dental Society.

Dr. Z. L. Edwards:

Mr. President, fellows: I am honest in saying that I don't really know what to say. I am not so sure but that you haven't made a mistake, but I promise to do my best to help you out of it. Now, in accepting your verdict as has been rendered, I do so in a spirit of humility and with the deepest appreciation. And the thing that I appreciate most is not so much the honor of being President of the North Carolina Dental Society, not so much the privilege of occupying the exalted position in our official family, as I do the manifestation of your confidence, which you have shown by your action. And I wish to say that when the time comes for me to assume the responsibility as your president, I shall do my best to live in keeping with the records of my predecessors. I thank you. (Applause.)

President Branch:

Gentlemen, next in order is Vice-President. Whom will you have?

Dr. J. N. Johnson nominated for Vice-President Dr. L. J. Meredith, of Wilmington; seconded by Dr. H. K. Thompson.

Dr. Paul E. Jones moved that the nominations be closed, which was seconded and unanimously carried. Dr. L. J. Meredith is duly elected Vice-President of the North Carolina Dental Society.

President Branch:

The next officer we have to elect tonight is Secretary-Treasurer. Whom will you have?

Dr. Wilbert Jackson nominated Dr. D. L. Pridgen, of Fayetteville, as Secretary-Treasurer. This was seconded by Dr. Dennis F. Keel and unanimously carried. The nominations were closed and Dr. D. L. Pridgen was elected.

From the Floor:

Who is Doctor Pridgen! (Laughter.) I never heard of him! (More laughter.)

President Branch:

Gentlemen, as you know, the terms of office of two of the Examining Board expire at this time. We first have to select a successor to the office now held by Doctor McClung. Whom will you have?

Dr. G. Fred Hale:

Mr. President, members of the North Carolina Dental Society: We are peculiarly fortunate in the North Carolina Dental Society of having a number of men who could ably fill that place. I don't think there is any argument there. The man whom I wish to place in nomination is eminently qualified and we don't have to argue that. His record on the State Board stands for itself. Dentistry is at the crossroads. Your State Board of Dental Examiners determine to a large extent the policies of the profession in your State. Doctor McClung has had the advantages of experience which, it seems to me, eminently qualifies him to succeed himself. If I understand it correctly, I think if Doctor McClung and Doctor Howle were both replaced by new members it would leave on the Board members with less than three years experience. I would like to place in nomination Dr. John A. McClung, of Winston-Salem, to succeed himself.

The nomination was seconded by Dr. Dennis F. Keel.

Dr. Paul E. Jones:

Mr. President: I believe the North Carolina Dental Society has certainly changed its policy very greatly since we were down here about three or four years ago. I remember when we were down here at that particular time and I happened to be one of the victims and I had a world of opposition. I don't think it is fair, we are not treating those others fair, it seems to me. So I arise to see if I can't stimulate a little opposition.

I agree with everything that has been said about my friend John McClung. I have been around over the country a good little bit and I have roomed with John from time to time and I have found him to be a fine fellow and I think he is a fine member of the Examining Board and all that. But in the meantime, I have other friends whom I think qualified and capable of rendering fine service to the North Carolina Dental Society from time to time and the man I wish to place in nomination has traveled far and wide in representing the North Carolina Dental Society ably. He is deserving and capable and I think the Examining Board is a very important position, one of the most important that the North Carolina Dental Society has to fill from its membership. It has always been filled by good men and in nominating this man, I feel that I am nominating a man who will carry on the work in the way that it has been carried on in the past. It is my happy privilege to nominate Dr. C. C. Poindexter, of Greensboro, to succeed Doctor McClung. (Much applause.)

The nomination was seconded by Dr. T. Edgar Sikes and several others. Dr. L. T. Smith moved the nominations be closed which was seconded and unanimously carried.

After the voting was over, Dr. Wilbert Jackson announced that Dr. C. C. Poindexter has received the majority of the votes cast and is, therefore, elected as a member of the Dental Board of Examiners.

Dr. John A. McClung moved that the election be made unanimous; the motion was seconded and unanimously carried.

Dr. C. C. Poindexter:

Friends of the North Carolina Dental Society: I only wish to say that I am grateful for the honor that you have just imposed on me. I deeply appreciate it and the evidence of friendship, particularly that coming from the boys back home at Greensboro and Guilford County. When I assume the responsibility of the Board of Examiners, I will not be unmindful of the high standards set by my predecessors. At this time I pledge to you my honest desire to maintain those standards. (Applause.)

President Branch:

Gentlemen, the next in order is a member of the Board to succeed Doctor Howle. Whom will you have?

Dr. F. L. Hunt placed in nomination as a member of the Examining Board, Doctor E. B. Howle, of Raleigh. It was moved, seconded, and unanimously carried that the nominations be closed and that Dr. E. B. Howle be unanimously elected as a member of the Examining Board to succeed himself. The motion was unanimously carried.

From the Floor:

Speech! Speech! Speech! Speech!

Dr. E. B. Howle:

Mr. President: I made my one and only speech last night. (Laughter.) It is needless to say that I appreciate the honor that you have bestowed upon me and I will serve to the best of my ability. (Applause.)

Dr. J. Martin Fleming, of Raleigh, was unanimously elected as the official delegate to the American Dental Association.

Dr. C. E. Minges nominated Dr. Paul E. Jones, of Farmville, as an alternate delegate to the American Dental Association. This motion was seconded.

Dr. Wilbert Jackson nominated R. M. Olive, of Fayetteville, as an alternate delegate. This motion was duly seconded.

Dr. N. Sheffield, of Greensboro, was nominated and later withdrawn as an alternate delegate to the American Dental Association.

Dr. Ralph F. Jarrett nominated Dr. J. A. Sinclair, of Asheville, as an alternate delegate to the American Dental Association, upon request, the nomination was withdrawn.

Dr. J. T. Lasley nominated Dr. Charles C. Poindexter, of Greensboro, as an alternate delegate to the American Dental Association. This nomination was seconded.

It was moved, seconded and unanimously carried that the nominations be closed.

The Secretary was authorized to cast the unanimous vote of the Society for Dr. Charles C. Poindexter, Dr. Paul E. Jones and Dr. R. M. Olive as alternate delegates to the American Dental Association.

President Branch:

We now come to the selection of the place of meeting. Invitations are in order and I understand the Secretary has some communications to read us first.

The Secretary read some communications from Pinehurst, Blowing Rock, and Raleigh, inviting the North Carolina Dental Society to meet in their city next year.

Dr. H. O. Lineberger spoke in behalf of the invitation from the city of Raleigh.

Dr. J. C. Watkins gave an official invitation to the North Carolina Dental Society to meet in Winston-Salem.

Dr. J. F. Reece of Lenoir spoke in behalf of the invitations from Blowing Rock.

Dr. P. E. Horton urged the North Carolina Dental Society to meet in Winston-Salem, also Dr. H. L. Keel.

Dr. Ralph F. Jarrett invited the North Carolina Dental Society to meet in Charlotte.

Dr. W. D. Gibbs urged the Society to meet in Charlotte.

Dr. E. M. Medlin requested the Society to meet in Pinehurst.

The privilege of offering invitations was then closed, and Blowing Rock receiving forty-seven of the votes cast was declared the 1935 meeting place of the North Carolina Dental Society.

The meeting then, at 11:00 o'clock p.m. adjourned.

THIRD DAY—WEDNESDAY, JUNE 20, 1934

Morning Session

The meeting was called to order by President Branch at 10:00 o'clock a.m.

President Branch:

Gentlemen and ladies: From what they all say, this is truly a morning after the night before, but we are on the home stretch and it has been one of the best meetings that we have had and this morning we have the dessert and it is going to be plenty good. It is my great pleasure to introduce to you at this time one of the best known men in the State, one of the best known men in the profession, not only in the State but out of the State also. Dr. Paul McCain, President of the Medical Society and Director of the State Tuberculosis Institution. Doctor McCain. (Applause.)

Dr. P. P. McCain:

CHILDHOOD TUBERCULOSIS

P. P. McCain, M.D.

Mr. President and members of the North Carolina Dental Society, I appreciate very much the honor of being invited to speak to you at this your annual meeting, both on my own account and also because it gives me the opportunity to bring to you officially the greetings of the Medical Society of the State of North Carolina. The cordial relationship which has always existed between our two professions has been most gratifying and we are confident will always continue.

The very fact that I was asked to speak to you on the subject of tuberculosis in childhood is an evidence of the breadth of your interest in matters pertaining to the public good. In this connection I want to congratulate the members of your profession in this State upon your hearty coöperation with the State Board of Health in their program of conducting dental clinics in the public schools. It is difficult to estimate the great amount of good which has been accomplished, not only through the dental defects which have been corrected, but also through the education of the school children to an appreciation of the importance of the proper care of their teeth and gums for the maintenance of good health.

At first thought the subject of childhood tuberculosis might be considered to have little connection with dentistry. One of the main factors in preventing tuberculous infections from developing into tuberculous disease and in preventing the childhood type of tuberculosis from developing into the more serious forms of the disease is to keep the child's resistance built up to the highest possible degree; and one of the important ways of keeping the resistance built up is through the proper care of the teeth.

During the last eight years the Extension Department of the North Carolina Sanatorium has been working in coöperation with county health and school authorities in making a study of the North Carolina school children for tuberculosis. We have studied during this time about 175,000 children. Our plan is to give the tuberculin test to all the children in the school being studied. On those who give a negative tuberculin test no further study is made. On those who give a positive reaction we make a general physical examination and an X-ray examination of the chest, one postero-anterior and one oblique film. In childhood tuberculosis the physical examination of the chest will not show any abnormal physical signs, but we make the physical examination to discover any other defects which may be present. Except in communities where dental clinics have been held, defective teeth practically always head the list of the defects discovered. We send a report to the parents of all the children examined pointing out the defects which have been discovered and urge them to take their children to their family physicians and dentists for the correction of these defects.

Childhood tuberculosis or, as some prefer to call it, primary infection tuberculosis differs very greatly from the usual form of

the disease which is associated in the public mind with so much dread and fear and which is often spoken of as consumption or the great white plague. The childhood type of the disease rarely causes any symptoms. The child usually looks and feels perfectly well. Not infrequently children having this type of tuberculosis are over weight and ruddy in appearance. Fortunately, too, this form of the disease is practically always curable. The disease usually persists in this childhood form for a period of years before developing into the more serious and so often fatal adult form. It is exceedingly important that the general public, as well as the members of the medical and allied professions, should have a clear understanding of childhood tuberculosis and the possibilities afforded through the discovery of the disease in this stage of bringing the great white plague under control. Until a few years ago tuberculosis was divided into only three stages—incipient, moderately advanced and far advanced. We now know that there are really five stages—tuberculous infection, childhood type tuberculosis and the three stages of adult tuberculosis—incipient, moderately advanced and far advanced. In the control of tuberculosis nothing is so important aside from prevention as the early recognition of the disease. For this reason I will dwell at some length upon the different stages of the disease and the relative possibilities of a cure in each.

1. *Tuberculous infection:* This can only be recognized by a positive tuberculin test, which most authorities now feel indicates the presence somewhere in the body of live tubercle bacilli. The bacilli are imbedded in the tissues of the body, but as yet they have produced no recognizable pathology. The individual is thought of as having infection, but no definite tuberculous disease. If all those infected with tubercle bacilli could be discovered in this stage, if they would have their defects corrected, if they would obey the general laws of health and if they would avoid exposure to further massive infection, practically none of them would ever develop definite tuberculosis. In our study of the school children of North Carolina we found that 16 per cent showed tuberculous infection. By pointing out these infections and by pointing out the proper course to follow we are in hopes that the clinics will be the means of preventing most of these infections from ever developing into disease.

2. *Childhood or first infection type of tuberculosis:* This represents the earliest demonstrable stage of the disease. It can rarely be diagnosed except by the X-ray and by a positive tuberculin test. As stated above, it is practically never accompanied by symptoms and abnormal physical signs. X-ray films usually show a small primary focus somewhere near the periphery of the lung, ordinarily not larger than a small pea or bean, and an involvement of the tracheobronchial glands into which the lymph from the area of this focus drains. If all cases of tuberculosis could be discovered in this stage, if further infection from outside sources could be avoided and if reasonable health rules could be followed, practically all cases could be cured at home under the care of their family physician with little expense and without the loss of time from school or work and before they become a source of danger to others.

3. *Incipient tuberculosis:* This stage represents the earliest form of the adult or re-infection type of the disease. In most cases there are no symptoms and either very indefinite physical signs or none at all. Usually there is no cough or expectoration and when sputum is present it is rarely positive. Only about 10 to 15 per cent of the cases diagnosed are in this stage, and most of these are discovered by the X-ray in the study of apparently well contacts, or in the study of large groups of apparently well people. Rarely do patients in this stage feel sick enough to consult a physician. Most incipient cases should be in a sanatorium for a period of from four to eight months. Practically all who have the proper treatment have a splendid chance of getting entirely well at comparatively little expense before becoming a source of danger to others. Only about one in six to eight hundred school children is found to have adult tuberculosis, either in this early or the later stages of the disease.

4. *Moderately advanced tuberculosis:* It is surprising how frequently patients even in this stage of the disease feel quite well and how many others have such slight symptoms that they pay them little attention. Many have slight cough and expectoration which they attribute to a cold or to smoking and many have other slight symptoms which they think are due to only temporary and insignificant causes. Most cases in this stage have positive sputum and have infected the other members of their households by the time their disease is discovered. The majority, but by no means all, have abnormal physical signs. Few in this stage are ever entirely cured. With proper treatment most of them can get their disease arrested, but it usually requires a year or more in a sanatorium, frequently with pneumothorax treatment or other forms of collapse therapy and cautious living for many years thereafter. About 40 to 60 per cent of cases have the disease in this stage when the diagnosis is first made.

5. *Far advanced tuberculosis:* In a large majority of cases in this stage there are both symptoms and physical signs and the sputum is almost always positive. Not infrequently, however, and especially in the Negro race, symptoms may have been present only a very short time. In spite of the best treatment many of these patients will wage a losing fight. By years of curing and by having the advantage of collapse therapy many such cases will be improved, practically none can be cured, almost all are infectious and even under the most favorable circumstances it will require a great deal of time and money for them to get their disease under control. The fact that 35 to 50 per cent of white and 50 to 75 per cent of colored victims of tuberculosis reach this stage before a diagnosis is made is sufficient explanation of the fact that the great white plague continues to claim annually its victims to the number of scores of thousands in our country alone.

What a tremendous difference, both to the patients themselves and to the community, between the discovery of the disease in the early or the late stage! Tuberculous infection is so widespread that children frequently become infected from servants or from visitors when there is no tuberculosis in the immediate family. For this reason it is important that all children should have the tuberculin

test and that all who give a positive reaction should have a careful study made, including X-ray films so that in case there is any tuberculosis present it may be discovered in time to be entirely cured.

We feel that the first step in the treatment of all children who have positive tuberculin tests, whether they have demonstable lesions or not, should be the location of the source of infections and the prevention of further infection. If there is a member of the family or a servant in the home who has tuberculosis with positive sputum, such a one, if possible, should be placed in a sanatorium and if this cannot be done it would be well, if possible, for the children in the home to be placed in the home of some relative. If this is not possible, it is exceedingly important for the open case of tuberculosis to practice rigid precautions so that he will not further infect the other members of the family. Children of course are more susceptible to infection than adults. When a physician discovers a case of tuberculosis he should give all of the other members of the household the tuberculin test and make a study of all positive reactors in order to discover any other possible cases in time to be cured.

Further treatment for the various groups is usually recommended as follows:

1. That those children having positive tests, but as yet no denmonstrable lesions, be permitted to lead normal lives, but that their resistance be built up to the highest possible extent by proper hygienic-dietetic living, by protecting them against preventable diseases and by correcting any defects which they may have in order that their infections may never develop into disease.

2. That those with childhood type lesions of slight or moderate extent, and those classified as suspicious be allowed to remain at home and continue going to school provided they can get reasonable hygienic and dietetic care, provided they will avoid strenuous exercise and will lie down for an hour, either at school or on returning home in the afternoon, and provided they will place themselves under the observation of their physician.

3. That those with childhood type lesions of any extent who have to continue to live in contact with an open case be placed in a preventorium unless the contact be otherwise broken or unless the contact is known to take the necessary rigid precautions to prevent further infection of the other members of the family.

4. That all children with extensive childhood type lesions be placed in a sanatorium or preventorium or that they be placed on a modified rest cure at home if their home conditions are suitable.

5. That all children with adult type lesions, except those which are definitely inactive, and all with definitely caseous tuberculous glands be taken out of school immediately and be kept at bed rest at home until they can be placed in a sanatorium.

It is recommended for all groups that they have periodic examinations including X-rays of their chest at intervals of from a few months to a few years, depending upon the severity of the lesions and upon whether or not they are still exposed to an open case of tuberculosis in the home.

The interest manifested in childhood tuberculosis in North Carolina, not only by the medical profession, but also by the public, has been most encouraging. Even though a very large proportion of the cost of the school clinics has to be borne by the local communities, and even in spite of the stringent financial conditions of the past few years, we have had so many requests for tuberculosis school clinics that we have not been able to supply the demand. When the importance of discovering tuberculosis in the childhood form becomes generally recognized a long step forward will have been made in the solution of the problem of the great white plague. (Applause.)

Now we have a few slides here.

(Slide.) Now this represents what used to be called early tuberculosis; as a matter of fact, it is not early tuberculosis. It is early adult type tuberculosis, but adult tuberculosis is a secondary disease. Now this sets up an area, a considerable area of infection and if not properly cared for it spreads and spreads. This represents the early type of the adult tuberculosis which is being recognized. This was in a doctor who stayed on the cure about a year and is now back in the active practice again. This usually is accompanied by some physical signs, but not always by any means. The only safe way of determining whether anyone has tuberculosis, positive tuberculosis in the adult type of tuberculosis, is to have an X-ray. This can be cured but it will take from three to four years usually to cure it. An individual will have to stay on the rest cure from four to eight months and even in the early stage the adult type tuberculosis is expensive. Most of these early adult type lesions do not have tuberculous bacilli in evidence. But even when discovered at this stage, it can be cured.

(Slide.) This represents a more extensive lesion with a moderately advanced lesion. This side over here is practically normal. You can see the infection over on this side. Only about ten to twenty per cent of adult type lesions are found in the incipient stage. About forty to seventy-five per cent of the adult type lesions that are found are in this moderately advanced stage or far advanced stage. This type of individual with this type of lesion can be improved. By the time it is discovered he has usually infected the other members of his family so he is a source of danger. It will take an individual like that probably at least a year in a sanatorium; many of them have to have various forms of collapse therapy to be thereby gotten under control, so that even when discovered a patient in that stage has tuberculosis that is quite a problem; it is expensive to the community. Most of them don't have the money to stop work and go off and stay in the sanatorium for months and months and to stay off of the job of work for two or three years. If that individual could have been found when a child, what a different proposition it would have been.

(Slide.) This is a far advanced type of tuberculosis, what is usually known as consumption, though this is a picture of a colored high-school girl who was going to school. She had a cough and was expectorating and, of course, she was infecting the other people of the school to which she went. She had trouble all through the lung and had considerable trouble over on this side. None of the cases

of this type ever get well. In the Negroes, about seventy-five to eighty per cent of the cases are in this far-advanced stage before they are discovered and have already infected all the other people of the family and frequently they have infected the white folks for whom they work. Week before last a doctor who owns a hospital, one of the most prominent doctors in the State, brought his little four-year-old boy down to the sanatorium to be examined because he gave a positive tuberculin test. We X-rayed him and found a tuberculous lesion in the bottom of each lung. That little fellow looked well, he felt well, but he was infected. The doctor's cook, colored cook, had had tuberculosis and died ten days after she stopped work. She had a big hemorrhage and the doctor didn't know before that she had tuberculosis at all. So this colored problem is important, not only from the standpoint of the colored people but from the source of danger that they are to the white people. Thank you. (Much applause.)

President Branch:

I personally want to thank Doctor McCain and I am sure that the Society concurs when we say that we greatly appreciate his coming down to bring this message.

There is one thing I would like to say at this time: I wish every dentist in the State could hear Doctor McCain's message as he presented it to us here this morning. And I trust that he will be invited as soon as possible to every dental meeting in the State for that purpose. Gentlemen, I have said time and time again that we have an unusual opportunity to serve the people of this State in bringing health truths to them; not taking it ourselves every time, but helping them to receive messages by bringing someone to them to deliver it, and also in giving it to us that we can take it to them in an acceptable manner. Doctor McCain, we appreciate very much your coming.

The next on our program is Doctor Brown, whom you have had in the meetings held here in the last two or three days, who will now speak to us on "Personality Measurements." That is the thing that you have been wanting to hear and we are glad to have Doctor Brown here. (Applause.)

Dr. R. K. Brown:

Mr. President, members of the North Carolina Dental Society and our better two-thirds: (Applause.) I don't think, Mr. President, that I should give this paper. This paper is headed "Personality Measurements." Now the flowers of Southern womanhood that I see here this morning, are much better instruments for measuring than anything that I could ever devise;

because I know my wife can measure my personality better than any person that I know of or any group of people. Now, this morning she said, "Bob, when you talk, keep your coat buttoned." (Laughter.)

I got my other pair of glasses broken at that party last night. (Laughter.) I haven't got my reading pair with me.

It is peculiar to see a dentist speaking on "Personality Measurements." My only excuse is that I have been a teacher and I was interested in trying to evaluate the personality of our students. The proper study of mankind is man; and we have been too selfish in the past; we have played with ourselves; we have led a shut-in life. I think that is true more often in the part of the country I am from than down here, because since I have come down here I can see that life goes on very much smoother and without that tenseness and excitement that we have in the North. And I wish I could come down here. I like that atmosphere; I would like to do more fishing and then down here you don't seem to have had a depression. (Laughter.)

PERSONALITY MEASUREMENTS

R. K. Brown, M.S., D.D.S., F.A.C.D.

The old order of dental economics or practice management, characterized by a selfish individualism, and catering only to those who could pay profitable fees, has been replaced by a new order whose members, following the trend of the times, believe dentistry to be a public health measure that should be made available to the masses.[1]

The dentist of today is not greatly interested in practice management and efficiency. He is overcoming a selfish interest in the purely internal problems of his practice, that frequently overshadow an obligation of service. He is studying the external problems that his profession presents, with their relation to health insurance, corporate and contract practice and other forms of socialized dentistry.

The dentist realizes that his horizon must broaden, and that mutual confidence between his patient and himself is essential to professional success;[2] the other essential factors are too many to enumerate, for there are scores of definitions of "success."

Few dentists in this country of ours are receiving what they deserve in the way of professional success. The biographies of successful dentists give convincing evidence that in addition to professional skill, ability, and knowledge, certain other outstanding factors have made these men stand head and shoulders above their colleagues; they possess well-rounded, pleasing personalities coupled with an understanding of human nature which is based on a recognition of the theory of individual differences. Contrary to general belief, we are not born equal, we do not live equal, nor do we die equal.

It is admitted that the dentist's patients do not know, nor are they capable of judging his skill, ability, or knowledge. The patient's final opinion of his dentist rests essentially on the satisfaction that he receives from the service rendered—perhaps relief from pain, betterment of health, or a restoration of function. Certain likes, dislikes, attitudes or prejudices may also have arisen from professional or social contacts, which may or may not have a firm foundation; nevertheless it would be of great value to the dentist to know of these reactions on the part of his patients.

There are certain psychologic elements that enter into professional life and tend to cover values with a veneer beneath which the patient seldom sees. These elements are the result of two things; first, the atmosphere or setting of the office of the professional man; and second, his *personality*.[3] A fine operator who has to combat unpleasant psychologic effects due to a poor professional environment and a weak personality will have his produce valued at far less than its intrinsic worth. This is particularly true of the dental profession, for our patients receive and pay (perhaps) for a service whose real value they seldom can see or appreciate.

The dentist is accepted or rejected by his clientele on the basis of objective symptoms or surface signs, along with his persuasiveness of appeal and the atmosphere of his office and its environment.

Let us remember this axiom—a practice in dentistry is built by the effect of appearance and retained by the value of its service. Dr. Edwin Kent[4] made a survey of over 500 of his patients, in which he asked the following question: "Disregarding any consideration of my operating ability, what is there about me or my office that is important in attracting your patronage?" The cleanliness and asepsis of the office and its personnel received the highest number of votes, while personality ranked second. We realize that the former item can be taken care of by all of us with a little study and attention. But how can we estimate or measure the effect on our patients of the second item, personality? It would be of great value to us if we could do so.

As has been said, professional knowledge and skill, combined with intelligence and industry, are not sufficient to enable us to attain success in our chosen profession. We realize that success also depends on an additional group of qualities of considerable importance in everyday living and working. These qualities or traits constitute an individual's personality.

Our personality is the sum total of the effect we have on other people, and we admit a curiosity as to what this effect may be. We realize that personality may be developed and controlled by the average adult, but he must *know what* to develop and control as well as *how* to develop and control it. It is ignorance of these factors that has left the control of personality to chance, which is more likely to subtract from one's success than to add to it.

As individuals we should like to know the answer to these questions:

1. What can one do to control his own conduct and attitudes so that he will be better liked by his fellow men?

2. How can one tell whether he is disliked without going through the embarrassment of asking his friends or associates?

3. What can one do to make certain that he is not being handicapped in his progress through life by making himself disliked unwittingly?

An individual may have as many personalities as there are individuals observing him, and it is the aggregate opinion of society, minus the halo effect, that he would like to secure. By means of a personality questionnaire it is possible to find certain attitudes and modes of conduct that need modification and control. Bernreuter's "Personality Inventory" is an example of this procedure.

The opinion of several of one's acquaintances, summarized by using the graphic rating scale method will divulge handicaps to a dentist's professional progress and show whether he is liked or disliked by his friends and associates as well as by his patients. Such devices measure personality with a fair degree of success, and we have hopes for greater accuracy in the near future[5].

Each one of us should frequently inventory his personal assets and liabilities, for such introspection or self-analysis will benefit every person who indulges in it. This procedure will be especially beneficial if we bear in mind that there are three major reasons why people may not like us, as given by Dr. Donald A. Laird[6] of Colgate after a long period of investigation. They are:

1. People dislike those of whom they are afraid. Sarcasm, making fun of one behind his back, and other reactions that engender fear causes dislikes to germinate.

2. They dislike those who deflate their ego, who build up their inferiority complex. This is done by domineering or bossing. They make one feel small in comparison with others.

3. They dislike people who do things of a petty nature of one kind or another that annoy and irritate them.

I am sure that a close analysis of your status in regard to these questions will be of value to you. You must develop the ability to get along with people and master the strategy of handling them.[7]

Personality study must be taken seriously but there are limits to its application. For example, Christian Gauss in the "Saturday Evening Post" for September 16, 1933, has written an article entitled, "How's Your Personality." In it he cites the example of Bill, a college student who would have been content to graduate from college, go back to his father's store in a small town, and become a respectable, small-town merchant. During his college career, however, he ran afoul of a personality expert, who, after numerous tests, decided that Bill would be happy and successful only as an international diplomat. The world lost a good small-town merchant and has not yet secured the international diplomat. This is an example of carrying personality analysis and vocational guidance to an exaggerated degree, with disastrous results.

Another extreme cited was the case of a worthy P. T. A. member who felt that the chief aim of education was to "strengthen the consciousness of self." As her young son arose each morning he was not greeted with "Good morning, John" but heard cheerily ringing in his ears, "Good morning, John Hatfield Winthrop. How's your

personality this morning?" Johnny's ego was thereby dilated and his consciousness enhanced.

This type of psychology is as extreme as the definition of personality given to Dr. Gauss by a personality expert, who defined it as the "congeries of coördinated attributes whose integrated functioning constitutes the effective essence of any particular psyche." This is as clear to me as why twelve eminently respectable Britons of great virtue and reputation left England within twenty-four hours after each had received the following unsigned telegram from Sir Arthur Conan Doyle, "Fly at once, all is discovered."

It is possible to help any one interested in a scientific personality analysis. This is accomplished by employing a third party who contacts individuals acquainted with the person under study. Valuable information has been secured by personnel workers who have followed this mode of investigation.

Many dentists are interested in this type of personal study and the results should be gratifying to each and every one of them. Their practices should receive a more lasting benefit than they could possibly derive from courses in practice management and so-called dental economics which do not develop a retarded or disintegrated personality. Let us repeat that to be a success in practice one must have not only knowledge and skill, but also a pleasing personality and an understanding of human nature. If a man is at all intelligent, he should be successful in the business conduct of his practice.

Personnel workers in industry have given us the "Sales Personality," a poor rule for measuring professional possibilities. Terman and Pittner, psychologists who have done so much for intelligence testing, are now turning their attention to the testing of the emotions, studying the character of the will and various other classes of traits, alone and in combination, that are found in the normal variations of an individual's personality. They feel, with Dr. R. S. Woodworth of Columbia, that "though intelligence is an asset in life it does not by any means cover all the deficiencies of one's equipment for life. The emotions need to be considered, as well as the health and energy of the individual, his persistence, poise, sociability, and many other characteristics that go to make up his personality."

What is the ideal personality that a dentist should possess in order to be successful? I have studied this question for over five years.[8] A hundred dental teachers, a hundred successful general practitioners of dentistry, and over three hundred dentists throughout the United States and Canada have selected from a list of fifty traits certain ones that a successful dentist should possess.

This study has been conducted by means of questionnaires and it has been found that a successful dentist should possess the following attributes:

He should be honest and of unquestionable integrity, reliability and sincerity, possessing initiative and aggressiveness.

He should possess emotional stability and marked self-control, displaying sympathy, tact, and courtesy in managing his patients.

He should be industrious, persevering and patient, yet resourceful and self-sufficient in meeting situations as they arise.

His personal appearance, manner, and bearing should be impressive, neat, and orderly.

He should possess a keen observation and a retentive memory, showing a personal interest in his fellow-men.

He should be able to accomplish precise results with great accuracy.

The final result of this study has been developed into the form of a personality rating scale, and its use was described in a recent issue of the *Dental Cosmos*. I was surprised to receive over one hundred and twenty-five letters asking for a personality analysis, each individual sending me the names of five or more persons whom he wished to have rate him. The Acting Dental Chief of the Navy and the head of the Department of Orthodontics of an eastern university were equally interested, asking for a number of scales to use in their work. We may be able to measure your personality as it is viewed by your friends. It is another key that may help unlock the door that opens to professional success.[9]

A person lacking the courage necessary to subject himself to a personality analysis may do the next best thing, go through a detailed self-analysis budgeting his assets and liabilities.[10] We are prone, however, to give ourselves the benefit of the doubt when we are attempting self-analysis and we invariably over-rate our own personality. It is more expedient to find out how we affect other people, how we are reflected in the social mirror.

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Now this is the rating scale that we use. Each instructor gets one of these scales for every student. After you send me the name of these ten patients of yours, I will send one of these

scales to each patient or friend. I am a neutral person; I will never divulge your name; I will never mention your name. Those are kept in my files and I will give you a summary of the results. To each of these names you give me I send a rating scale. After you give the names of the individuals, I will mail this letter and the rating scale to each individual you select to judge your personality. This letter would be addressed to one of those raters. The patient fills out the scale and sends it to me. I strike the average and make out a master scale and I write a letter to you which gives the results.

Now, if you are willing to be hung on the line to dry and be looked at, all you have to do is to send me the paper with the individuals you would like to act as raters and it will be just a confidential arrangement between anyone of you and me.

In closing I would like to say that Mrs. Brown and I have certainly enjoyed our meeting with you. I wanted to come down here, I wanted to see these good looking women that we have heard so much about up North, and I can say now from first-hand knowledge that everything they have said about the women of the South is true. I have learned a great deal about how you live down here. I don't think there is a North and a South anymore; although, one gentleman did call me a damned Yankee—the only time I was ever called that. (Laughter.) But my wife and I have enjoyed it very much. I have heard of your hospitality and you have lived up to it. I spent a night in the home of one of your North Carolina dentists and I was surprised; I frankly was surprised: My wife and I sat down at the meal with two fine sons and those sons sat and listened to us, and in my part of the country we sit and listen to our children. You have a great many customs that are a pleasure to see and we have had a very wonderful time. I hope every one of you will come to Michigan and come in to see us.

And all I can say to you now in closing is that I wish you all the success in the world, and God bless you. (Applause.)

President Branch:

I would like to say to Doctor Brown and Mrs. Brown that we are delighted to have the privilege of having them in our midst. I am sure his coming has been a great contribution toward the success of our meeting.

The next man on our program is one of our number and he certainly needs no introduction to us. Dr. Jackson Sinclair, of Asheville. (Applause.)

Dr. J. A. Sinclair:

Mr. President, ladies and gentlemen: I have looked forward to this opportunity of addressing the North Carolina Dental Society for some time. I have some thoughts and ideas that I should like to have recorded and I want them to be first recorded in the improving of the North Carolina Dental Society. It is a result of work that I have been doing for a number of years. It might not be of interest to all of you, but I hope some of you may get something out of the paper and take it back home, and I hope it will be of some benefit to you.

We deal with infection perhaps more than the medical profession. Perhaps ninety per cent of our work is the result, direct or indirect, of bacterial invasions, and we have neglected that side of it. The result, the reaction of the host to the bacteria and also of the bacteria to the host, these things must be considered.

INFECTION AND IMMUNITY WITH SPECIAL REFERENCE TO PERIODONTAL DISEASES AND TO "DRY SOCKET"

J. A. Sinclair

The course of an infection depends not only upon the nature, the number, and the virulence of the infecting agents, but also upon the behavior of the infected body. One must consider a disease as the result of the interaction of both of these factors without necessarily being able to attribute the various symptoms to either the one or the other. Although the general reaction of the organism is varied, it can nevertheless be shown that in spite of even individual differences, the characteriistic bacteria and their products bring about a distinct symptom-complex, which is usually concomitant with a significant defense on the part of the organism. The means which the body employs in this protection are cellular and humoral in nature. In fact, there is a group of infectious diseases in which the cellular reaction predominates, and another in which humoral changes are preëminent; and between these extremes are various intermediate forms. After the individual has recovered from an infectious disease, he passes into a state where he is less or even not at all susceptible to the same infection. This condition is one of immunity.

In most infections the host's reaction to infection is in a beneficial or curative way. Numerous observations, both clinically and experimentally, have afforded instances to the contrary condition, in which the individual is more susceptible. A condition in which a change has taken place in the host and not in the bacteria involved.

The simplest introduction to a discussion of the mechanisms involved in antibacterial immunity is a brief description of the way in which the living tissues deal with certain dyes and suspensions.

Briefly, these studies have shown that the various dyes are stored in the form of granules, in intracellular vacuoles, by certain cells that

have a characteristic distribution throughout the body. The histologist calls these cells histiocytes, the immunologist knows them best by Metchnikoff's name, macrophages. The most active may be divided into two main types, the sessile and the wandering. The most active of the sessile histiocytes are those found in certain specialized areas of the vascular or lymphatic endothelium—the endothelium of the liver capillaries (Kupffer cells), of the spleen sinuses, of the venous sinusoids of the bone-marrow, of the capillaries and medullary sinusoids of the adrenals, of the capillaries of the pituitary glands, and of the sinuses of the lymph glands throughout the body. Somewhat less active in this respect are the reticulocytes, which do not form a lining to blood or lymphatic channels, but are disposed about the reticulum fibres in the interstices of the tissues. The wandering histiocytes are found throughout the tissue spaces, and some of them find their way into the circulating blood, particularly into the vessels of the internal organs.

The common character of dye-storage possessed by cells of this type has led many observers, and particularly Aschoff (Aschoff, L., 1924. Ergebn. inn. Med. Kinderhlk., 26, I), to regard them as an integrated system of cells fulfilling a particular bodily function. Aschoff has coined for them the generic term of reticula-endothelial system. This system, as described by him, is summarized in schematic form as follows:

RETICULO-ENDOTHELIAL SYSTEM

(R. E. System)

Sessile Histiocytes (*Sessile Macrophages*)

Very Active	*Less Active*
Endothelium of:	Reticular cells of:
Liver capillaries (Kupffer cells)	Spleen
Spleen sinuses	Lymphatic glands and tissues
Lymph sinuses	Thymus
Marrow sinuses	
Adrenal capillaries	
Pituitary capillaries	

Wandering Histiocytes (*Wandering Macrophages*)

Tissue histiocytes (tissue macrophages)	Blood histiocytes (blood macrophages)

There is probably some degree of functional differentiation between different parts of the reticulo-endothelial system. Some histiocyte depots may be more active in removing effete blood-corpuscles or leucocytes, others in removing bacteria or smaller particles. There is also a difference between one animal species and another in the relative activity of the various depots of sessile histiocytes. Thus the bone-marrow of the mouse is far less active than the bone-marrow of the rabbit. (Cappell, D. F., 1930, *ibid.*, 33, 429.) In birds, the mass of the reticulo-endothelial system is concentrated in the liver.

The histiocytes are not, however, the only phagocytic cells with which we are concerned. The polymorpho-nuclear leucocytes of the blood, although they do not take up vital stains in the same way as the cells of the reticulo-endothelial system, play an active part in removing particulate material from the circulation under certain specialized conditions.

There is no doubt at all that the mechanism brought into play in clearing the blood stream of bacterial cells is in the main identical with that which frees it from inert particles of the same order and size. (Bartlett and Ozaki, 1917, J. Med. Res., 35, 465; 1918, *ibid.*, 37, 139) (Wright, H. D., 1927. J. Path. Bact., 30, 185.) The reticulo-endothelial cells, particularly those of the liver, spleen and bone-marrow, actively phagocytose the injected bacteria. The mechanism of aggregation, followed by the removal of the bacterial aggregates from the general circulation by their retention in the lung capillary, is sometimes very prominent. (Bartlett and Ozaki, 1917 and 1918, Dudgeon and Goadby, 1931, J. Hyg., 31, 247.) This is accompanied, as in the case of the intravenous injection of carbon particles, by the accumulation of polymorphonuclear cells in the lung capillary, associated with the temporary peripheral leucopœnia. The polymorphonuclear cells play a more active part in phagocytosing bacteria than in phagocytosing carbon particles. (Dudgeon and Goadby, 1931.) It is probable that these cells with their ingested bacteria are subsequently carried to the reticulo-endothelial depots in the spleen, liver and elsewhere, and are there phagocytosed by the sessile histiocytes. Such wandering histiocytes as are present in the lung capillaries ingest the bacterial cells directly.

The bacteria that we inject are alive and capable of multiplication; and it is the balance between their capacity to multiply and the capacity of the tissues to remove them that determines the fate of the animal host.

Wright (Wright, H. D., 1927, J. Path. Bact., 30, 185), has carried out a very detailed series of experiments on experimental pneumococcal septicæmia in the rabbit, and the following illustrative examples are taken from his paper. Living pneumococci per c.c. of circulating blood at stated times after inoculation of avirulent, slightly virulent, and highly virulent pneumococci into normal rabbits.

Time	*Avirulent*	*Slightly Virulent*	*Highly*
Immediately	8,900,000	1,030,000	1,070,000
2 hours	206	20,800	137,000
5 hours	2	340	25,000
24 hours	0	1,300	1,510,000
48 hours		340	Dead
96 hours		0	

In the above table are set out the numbers of living pneumococci per c.c. of circulating blood at varying intervals after the intravenous injection of (a) an avirulent, (b) slightly virulent, (c) a highly virulent strain. With an avirulent strain the clearance of the organisms from the blood stream is rapid and permanent. With a slightly virulent strain there is the same rapid initial clearance, so

that 99 per cent of the injected organisms have been removed from the blood stream by the end of the fifth hour. There is then a period during which the capacity of the strain makes itself felt, and the number of viable organisms rise from 340 per c.c. at the fifth hour to 1,300 per c.c. at the twenty-fourth hour. The clearing mechanism is now removing the newly generated bacterial cells at a greater rate than this particular strain can produce them and the blood is sterile by the ninety-sixth hour. The highly virulent strain is not proof against the initial action of the clearing mechanism. By the fifth hour 97 per cent of the injected pneumococci have been removed from the blood stream. When the parasites' capacity for multiplication is brought fully into play it overwhelms the defense mechanism of the host. By the twenty-fourth hour the number of pneumococci per c.c. of circulating blood has risen to 1,510,000; and between the twenty-fourth and forty-eighth hours the rabbit dies from acute septicæmia.

There seems little doubt that the more significant happenings are those that occur between the fifth and twenty-fourth hours after an intravenous inoculation; when the fate of the host is being determined by the balance between bacterial multiplication, on the one hand, and the removal of the newly produced cell on the other.

Even when the tide has for the moment turned decisively in favor of the host, it does not follow that there will be a complete sterilization of the tissues. Bacteria will have been caught up in the liver, spleen, and elsewhere, and there some of them may remain alive but relatively inactive for a considerable period.

The reaction of actively immunized animals toward a virulent strain of a particular pathogenic bacterium is the same as a normal animal behaves toward an avirulent, or slightly virulent, strain of the same bacterial species. Wright, 1927, studied the response to the intravenous injection of virulent pneumococci of rabbits that had been immunized by the injection at various intervals before the test of a killed culture of the same strain.

The following chart shows the results obtained in two rabbits that had been immunized three months previously and in two normal controls injected with the same dose of the same living culture.

This chart will show that the immunized rabbits dealt with the highly virulent culture in the same way as the normal rabbit of the previous chart dealt with the slightly virulent strain.

Time After Injection	*Normal*		*Immunized*	
	Rabbit 247	*Rabbit 248*	*Rabbit 299*	*Rabbit 300*
Immediately	870,000	1,100,000	1,000,000	1,000,000
5 hours	1,300	3,300	12	68
24 hours	142,000	1,953,000	0	289
48 hours	2,800	Innumerable	149	79
96 hours	Dead	Dead	0	0

Thus we see an immunized animal reacts to a highly virulent bacterium as does a normal animal to one of lower virulence. The exact degree of difference in behavior depends upon the grade of immunity that has been established.

A fact of the greatest significance is that the increased resistance that an actively immunized animal enjoys, in virtue of an increased efficiency of the defense mechanism considered above, can be passively transferred from an immunized to a normal animal by injecting into the second the blood serum of the first.

That this passive transfer of an immunity depends on an increased efficiency of phagocytosis had been demonstrated long before the part played by the reticulo-endothelial system has been brought to light, and when the polymorphonuclear cells, or microphages, were regarded as the principle phagocytes of bacteria.

In all cases the passage of the bacteria from the primary site of infection to the blood stream is mainly by way of the lymphatics, and the histiocyte depots in the regional lymphatic glands play a prominent part in the removal of the invading bacteria. When relatively avirulent bacteria gain access to the tissue at some site from which passage to the blood stream is slow, infection may never pass beyond the first line of defense and the regional lymphatic glands.

The part played by phagocytosis in the healing of wounds is clearly demonstrated in the removal of a tooth affected with pyorrhea. While the tooth is in place the pocket is external to the body cells, that is its opening is into the oral cavity. The phagocytic defense does not extend and engulf the diseased tissue. A large portion of the diseased tissue is exposed to the center of the pocket which in turn is exposed to the oral cavity. When the tooth is extracted blood coagulates filling the socket completely; the diseased tissue is then within the body tissue, surrounded by a wall of defense. The leukocytes having access to the bacteria from all sides, the monocytes engulfing any necrotic tissue that may be present. The bacteria besides being surrounded by phagocytic leukocytes, are in a solution of serum containing the specific antibody, freeing the tissue of bacteria and their product and the lesion heals.

In addition to this process of removal by phagocytic cells, a direct bactericidal action of the serum plays a part in ridding the tissue of bacteria. The importance of this purely humoral immunity appears to differ widely in different bacterial infections; but it is probably always subsidiary to the phagocytic mechanism, and is seldom, if ever, the main factor in defense.

When a man or animal contracts an infectious disease substances make their appearance in the blood stream that react in the test tube with the organism that is causing the infection or with its products. They may cause the clumping, or agglutination, or a uniform dispersed suspension of bacteria; they may kill them, often with a partial disruption of the bacterial cell that we refer to as lysis; they may alter them so that they are more easily taken up by phagocytes; they may form a precipitate when added to an extract of the bacterial cells or they may neutralize a bacterial toxin. Substances of this kind can be caused to appear in the serum by the injection into the tissues of materials of the most diverse kind; bacteria, living or dead; bacterial toxins or extract; foreign cells, such as the red blood corpuscles of some other species; foreign proteins, such as milk, egg albumin, vegetable protein or the blood serum of some other animal. The substances that appear in the serum are

called antibodies; the substances that induce their formation and react with them when formed are called antigens. The antigen antibody reaction plays a large part in the defense mechanism of the host in all virulent infections.

The typical pyorrhea lesion cannot be reproduced in animal experimentation because of the avirulent nature of the causative organism, we cannot study the successive tissue changes taking place in the complete evolution of the lesion. Miller inoculated pus from pyorrhea in man into the gums of healthy dogs. He says slight inflammation always ensued and in one case a little suppuration, but in a week all cases were completely healed. Talvin (H. F. Talvin, Dental Digest, 1928, xxxiv, 248) failed to reproduce the disease by inoculation of material into healthy animals. T. D. Smith (Fuso-Spirochetal Disease, Williams and Wilkins Company, 1932, 70) with the assistance of Richardson and Bowers and Ryan, inoculated a series of normal guinea pigs and rabbits with material scraped from the gums of patients with pyorrhea. A number of these animals developed acute ulcerative lesions of the gums, but all healed promptly without becoming chronic.

Further investigations as to the causative microbial parasite in the pyorrhea lesion may show that as in the case of diphtheria, syphilis, or tetanus, a single specific parasite is involved. We may, however, find that the disease involves several distinct bacterial species as alternative infecting agents. Secondary pneumonia affords one example bacillary dysentery another.

Smith (Fuso-Spirochetal Diseases) claims that among other factors in the development of pyorrhea there is a specific infection with the same symbiotic group of anaerobic organisms which are present in fuso-spirochetal angina, noma, and necrotic gingivitis. In 201 cases of pyorrhea Fisher (John, H., American Journal Med. Ci., 1929, cixxviii, 20) found endamnoeba gingivitis in 95 per cent, fusiform bacilli and spirochetes in 100 per cent and streptococus viridans in thirty cases. In one hundred and fifty cases on clinical pyorrhea, Winthrop (J. Paul, Dental Digest, 1929, xxv, 381) found fuso-spirochetal organisms in all but twelve and some of these were cases which were undergoing antiluetic treatment. Talvin (H. F. Talvin, Dental Digest, 1928, xxxiv, 248) found fuso-spirochetal organisms in the gums of everyone of six hundred patients with pyorrhea in the United States Public Service Hospital of Hot Springs, Arkansas. Leary (Timothy Leary, *Dental Cosmos*, 1910, lii, 52) found fusiform bacilli and spirochetes constantly in one hundred cases of pyorrhea.

Unless there is discovered a way to identify the causative agent or agents in avirulent infections we must rely upon probabilities derived not only from the continued presence of one or many bacteria, but we must depend upon comparative pathology in our discussions of pyorrhea.

In the body's effort to rid itself of the bacterial stimulant, tissue changes in pyorrhea take place that are related to the heterogenous group which includes the tubercular bacillus, the leprosy bacillus, the treponema pallidum, the actinomyces bovis, the actinobacillus and

the glanders bacillus which give rise to the group of diseases known as the infective granulomata.

This group of diseases are characteristically chronic in their life cycle. They produce a characteristic blood picture that is applicable to all. They are all allergic in their tendencies. The pre-allergic stage varies from a few days in syphilis and tuberculosis, to as high as thirty years in leprosy.

The essentially destructive character of the late lesions of syphilis, as distinguished from the early lesions, which are not destructive, has been a matter of considerable speculation. Since the spirochetes have been difficult to demonstrate in late lesions, and therefore have been presumed to be few in number in them, the natural assumption to explain the destructiveness of these lesions has been that the tissue has become more sensitive to the organism as time goes on, and finally reaches the stage where it is capable of reacting in a maximal fashion to a minimal stimulas. The name "Umstimmung" was given by Neisser to this change in the reacting capacity of the tissues; it is obviously another word for "allergy." (Alan Chesney, M.D., Internal Medicine, Musser, 219.)

The tissue response to the first tuberculosis infection at the site of infection is regular and uniform. There is no visible tissue change for the first few days following the inoculation. This uneventful period is followed by the appearance of a pale and rounded nodule arising out of a non-inflamed background. This rounded nodule gradually assumes a more irregular outline and the zone of skin immediately embracing the nodule is taking on a pinker hue. When this last change has taken place the host pre-allergic phase of tuberculosis has been completed. The nodular tubercle is the type of structure devised by the susceptible animal, unaffected by allergy, to meet the activities of tubercule bacilli. It is developed in a slow and indolent manner. It is sharply delimited from the tissue in which it is set, and it forms without the signs of acute inflammation. It arises without redness, heat or pain. After nodular tubercle is well established signs of inflammation appear, the beginning of the allergic state.

The formation of granulomata and the long exposure required for infection dominates the picture of leprosy. Latent infection may persist for years. Rogers (L. Rogers, Treatment and Prophylaxis of Leprosy, Edinburg Med. Jou., 1930, 2, 17) states that the incubation period in 80 per cent of the cases did not exceed five years. Periods as high as thirty years exposure before clinical manifestation of the disease appear is on record.

In all patients suffering from a periodontal infection, as in most chronic infections, the blood picture is changed from its normal differential count to one in which the granulocytes are reduced in number (Neutropenia) and the lymphocytes (Lymphocytosis) are increased. The monocytes may be normal or increased. In cases of long standing a leucopenia may exist. The blood picture is always of a lymphoid character. The hæmoglobin per cent is always moderately low—seventy or eighty.

Jones (Cecil Price-Jones, M.D., Blood Pictures, William Wood and Company, 1933, page 35) states:

"The coccal infections as a class produce a polymorphonuclear response, associated with the formation of pus, and is known as a pyogenic infection. The bacilliary infections on the other hand produce as a rule a lymphoid blood picture."

Without entering into the bacteriological aspect of the question, it may be stated that in general the majority of acute inflammatory conditions are due to infection by some variety of coccus. When the inflammation is very severe or prolonged, it proceeds to suppuration, ulceration, or abscess formation. The inflammation set up by the bacillary organisms is, generally speaking, of a less acute nature than that caused by coccal organisms; it is often of a catarrhal character, and associated with fibroblast scar-tissue formation. Suppuration occurs only in the later stages, or as a result of a superimposed coccal infection.

Hemogram Schilling Date.....

Hemoglobin	Hemoglobin GMS. Per 100 cc. Blood	Color Index	Erythrocytes	Leukocytes	Basophiles	Eosinophiles	Neutrophiles: Myelocytes	Neutrophiles: Juveniles	Neutrophiles: "Stabs"	Neutrophiles: Segment	Lymphocytes	Monocytes
80/100			5,000,000	6,000	1	2			4	63	24	6

Hemogram Schilling Date.....

Hemoglobin	Hemoglobin GMS. Per 100 cc. Blood	Color Index	Erythrocytes	Leukocytes	Basophiles	Eosinophiles	Neutrophiles: Myelocytes	Neutrophiles: Juveniles	Neutrophiles: "Stabs"	Neutrophiles: Segment	Lymphocytes	Monocytes
70			4,000,000	4,500	1	3			2	54	32	8

The above hemogram represents a normal differential count. The second differential represents the typical count of a patient with a long standing case of pyorrhea.

The problems that confront the dental profession must be worked out by the dentists themselves. Scientists building the structures of infection and immunity are not interested in our problems unless the organism becomes virulent.

This is expressed by Topley (Outlines of Immunity, page 100), where he states:

"The antibodies produced as the result of inoculating bacteria into laboratory animals seem to correspond to the bacterial surface,

rather than to the bacteria as a whole." We have noted also that rough variants are usually avirulent and avirulent bacteria are ipso facto of minor interest to the student of infective disease. The antigens that primarily concern us are those that characterize the surface of the normal, smooth, virulent form of pathogenic bacteria.

Pyorrhea is not a disease of youth, though youth is not exempt. As age advances the occurrence of the disease increases until finally as old age arrives there are but few who are not edentulous as the result of the final breaking down of the supporting tissue of the teeth.

During this period from youth to old age, the same symbiotic group of micro-organisms are present. They are perhaps present in greater number in youth, a period of neglect and uncleanliness, a period of "diseases of youth," which lower resistance. Many patients suffering from tuberculosis, syphilis, diabetes, pellagra, and other pathological conditions that lower resistance, do not have pyorrhea. Many patients in apparently perfect health have extensively destructive lesions. In the pyorrhea lesion with its typical granulomatous tissue, the long exposure to the bacterial flora of the mouth before clinical signs appear, the typical end product of the bacteria-tissue contact, the chronic course pursued, the lymphoid blood picture, the rapid healing of the lesion following the extraction of contact teeth, all suggest the causative agent as being an avirulent organism, or group of organisms of the bacillary group. The lesions suggest an allergic condition independent of lowered resistance but depending upon tissue sensitiveness for its activity.

"Dry Socket"

In condensing osteitis produced by trauma, devitalization, gritting the teeth, etc., there is little or no lateral blood supply to supply the blood clot that follows these difficult extractions. The clot must get its blood supply from the apical and gingival vessels; this distance is too great to supply the center of the clot before necrosis and decomposition begin. This decomposition extends from the center into the vital portion of the clot and soon the whole clot is thus destroyed producing the so-called "dry socket." In the extraction of normal, movable or loose tooth this does not occur, as a lateral circulation together with the apical and gingival circulation is sufficient to supply the clot with new circulation.

To overcome this condition the removal of a strip of labial or buccal plate to the apex area will cause the gum tissue to supply sufficient lateral circulation to maintain the clot in perfect health. In the upper molars a palatine strip as well as a buccal strip should be removed. In lower molars and bicuspids a removed lingual strip will be sufficient. In the third molar a lingual strip may be sufficient unless the tooth is deeply embedded in the bone. In this case the clot should be reduced in size by a sufficient pack that reduces the clot to at least two-thirds of the socket. This pack should remain in place without removal or changing for a period of ten days to two weeks.

I am very glad to have had the opportunity of presenting this subject to you in the North Carolina Dental Society and I hope some time that you will again give me the opportunity of talking to you perhaps on some other things. I thank you very much. (Applause.)

President Branch:

I am sure that we appreciate that, Doctor Sinclair.

We are running late and it is necessary now that we adjourn and go immediately into the meeting of the House of Delegates, gentlemen.

The meeting then, at 12:15 o'clock p.m. adjourned.

THIRD DAY—WEDNESDAY, JUNE 20, 1934

Meeting of House of Delegates

The meeting of the House of Delegates was called to order by President Branch at 12:15 o'clock p.m.

The President declared a quorum present and the meeting is ready for business.

Dr. Z. L. Edwards, made the following report for the Executive Committee:

REPORT EXECUTIVE COMMITTEE NORTH CAROLINA DENTAL SOCIETY

Following the usual custom a short meeting was held immediately following adjournment of our last annual convention for the purpose of electing an Editor-Publisher and deciding a tentative meeting date for our 1934 meeting. Your committee, recognizing the high degree of efficiency with which the affairs of the office of Editor-Publisher had been administered since the inception of the office and realizing the capabilities and the zeal with which the present Editor-Publisher had always performed his duties, the Executive Committee was unanimous in its desire to reëlect Dr. Fred Hale of Raleigh to succeed himself. It was deemed unwise to set a meeting date at that time because of the possible conflict with plans of the hotel management and meeting dates of some of our sister state associations.

The next meeting was held jointly with the Program Committee at the Carolina Hotel, Raleigh, N. C., for the purpose of discussing our program and the adoption of a budget. In doing this members of both committees emphasized the importance of putting on the best program possible consistent with the Society's income.

At this time resolutions from the First District Dental Society requesting the Executive Committee to change the meeting place of

our 1934 annual convention from Wrightsville to some more centrally located city. This request was given careful and sympathetic consideration and after a free and frank discussion the committee was unanimous in the opinion that while it did have the legal right to change the meeting place it had no moral right to exercise such arbitrary authority except in an extreme emergency. This committee, believing in the democratic principles of this organization and being devoted to the philosophy of government that the majority should rule, desire to express the opinion that this or any future Executive Committee would be setting a bad precedent and would be unfaithful in its duty if it yielded to the influence of the few and changed the meeting place from that selected by the majority voting in general convention assembled, except as stated above, wherein an emergency existed.

Some time after this meeting the Oceanic Hotel, at Wrightsville, which was to be our convention headquarters, was burned.

The management of the Tide Water Power Company was of the opinion at that time that the hotel would be rebuilt in time for this meeting. After waiting a reasonable length of time for some definite information, and owing to the necessity that the Secretary of our organization have blue prints of the exhibit space, your committee felt that new headquarters should be selected.

When we met at Wilson for that purpose a petition signed by all of the ethical dentists of Wilmington was presented requesting that we select Hotel Cape Fear, Wilmington, N. C., as our convention headquarters. The chairman of the Program Committee reported that all of the major clinicians had been engaged for June 18-20th. Keeping in mind the wishes of the Society in selecting the beach as its meeting place and realizing that the major clinicians had been engaged and the meeting dates set, the Executive Committee felt that in view of the fact that Wilmington was in close proximity to two beaches that its selection for our 1934 convention was more nearly in keeping with the wishes of the Society than some other city at this season of the year.

The Executive Committee believing that the trend of the times indicate that we are approaching a new era in our social, economic and professional life, recommended to Dr. E. A. Branch, President, North Carolina Dental Society, the appointment of a special committee whose duty it would be to make an investigation and study of our relief and allied problems in the hope that from their recommendations the Society would be able to adopt a definite policy in regards to caring for the needs of the indigent. My information is that this committee has been appointed and is now at work.

In conclusion, the Executive Committee desires to commend the able and conscientious leadership of your President, Dr. E. A. Branch, during the past year. We again commend the efficiency with which Dr. D. L. Pridgen and Dr. Fred Hale have performed the duties of their respective offices. The chairman of the Publicity Committee, Dr. Frank Alford, has done a splendid job in giving the meeting publicity. We desire to express to Dr. H. L. Keith, Chairman, General Arrangements Committee; Dr. Junius Smith, Chairman, Entertainment Committee and to all of the dentists of Wilmington our appre-

ciation for the splendid manner in which we have been taken care of and entertained. We desire to express also our thanks to the ladies of Wilmington for their most gracious hospitality and the entertainment furnished the visiting ladies. Lastly we desire to express our appreciation to the police department for the tolerance which they have exercised toward us during the meeting.

Respectfully submitted,

Z. L. Edwards, *Chairman.*
R. M. Olive.

It was moved, seconded, and unanimously carried that the report of the Executive Committee of the North Carolina Dental Society be received.

President Branch:

Doctor Smith, Chairman of the State Institutions Committee, has asked that he be allowed the privilege of just handing in his report. Without objection, that will be allowed.

REPORT OF STATE INSTITUTIONS COMMITTEE

Your State Institutions Committee respectfully submits the following report:

So far as your committee can ascertain, the following institutions have whole-time dentists:

State Hospital, Raleigh; State Prison, State Sanatorium.

Those having part-time dentists or dental work being taken care of by dentists in nearby towns are:

State School for the Blind, Orthopedic Hospital, Caswell Training School, State Hospital, Goldsboro; Samarcand, Jackson Training School, State Farm Colony.

The following institutions do not have adequate dental service:

State Hospital, Morganton; School for Deaf and Dumb.

The committee would like to recommend that dental work in these latter institutions be taken care of in some way.

Everett Smith, *Chairman.*
J. R. Edwards,
Oscar Hooks,
J. L. Ashby,
John R. Pharr,
Victor Bell.

President Branch:

The Legislative Committee has asked the same privilege; in that their report cannot be completed at this particular time, due to something that they have under consideration; and this committee has asked that they be granted the privilege of filing their report later on. The chair will grant this permission, if there is no objection.

President Branch:

The Examining Board report, they ask the same permission, inasmuch as there is nothing unusual in the report, they advise. It is their desire to save time, and that will be filed with the Secretary for publication, at which time you will have an opportunity of reading it. Without objection, the chair will grant that permission.

REPORT OF THE TRANSACTIONS OF THE NORTH CAROLINA STATE BOARD OF DENTAL EXAMINERS

January 1, 1934.

To His Excellency, J. C. B. Ehringhaus,
Governor of North Carolina,
Raleigh, N. C.

Dear Sir:

In accordance with the provisions of the Dental Law, I beg leave to hand you, herewith, a report of the proceedings of the North Carolina State Board of Dental Examiners for the year 1933 A.D.

A special meeting of the Board was held in Raleigh on Monday, May 22, 1933, for the purpose of hearing charges preferred against Dr. J. E. Owen of Asheville. All members were present, President J. A. McClung, presiding.

Doctor Owen was accused by Drs. C. C. Bennett, Ralph Little and Carey Wells, of advertisement of fraudulent claims and of employing unlicensed persons to practice dentistry.

After lengthy consideration of the case, complete minutes of which are on file, the meeting adjourned to resume hearing in Chapel Hill at 2:00 p.m. Tuesday, June 6, 1933, at which time the hearing continued and at the conclusion of same the Board voted unanimously to cancel the license of Doctor Owen.

Notice of appeal to Superior Court was filed by Doctor Owen with the Secretary of the Board of Dental Examiners.

The Board met in special session in the Wake County court room at Raleigh, N. C., at 10:00 o'clock a.m. on Saturday the 18th of November, 1933, in accordance with notice issued by the Secretary and for the purpose of considering and passing upon additional accusations against Dr. J. E. Owen of Asheville, N. C., by the accusers, Drs. C. T. Wells, C. C. Bennett and R. A. Little, all of Buncombe County.

Doctor Owen was charged with soliciting professional business, as a result of certain signs displayed upon the outside walls of the building in which his offices are located and of the circulation of certain advertisements in local newspapers.

After hearing the evidence in the case, complete record of which is on file, the Board unanimously revoked the license of Doctor Owen.

Notice of appeal to the Superior Court was filed with the Secretary of the Board.

On the same date and at the same place, the Board met at 3:00 o'clock p.m. for the purpose of considering and passing upon the

formal accusations recently filed by Drs. L. M. Daniels, R. P. Shepard, E. M. Medlin, L. J. Pegram and F. H. Underwood against Dr. George G. Herr, a duly licensed dentist of Southern Pines, Moore County, North Carolina.

Doctor Herr was charged with soliciting professional business as a result of the circulation through the mail or otherwise, over his own signature, of a circular letter calling attention to a reduction in his fees.

The facts in the case having been presented by the accusers and the accused, decision of the Board was as follows:

1. That as a matter of fact, the writing and circulation of the letter complained of, constitutes the offense of solicitation, and that the accused Dr. George G. Herr, by the writing and circulating of said letter, has violated Section 22 of the laws governing the practice of dentistry in the State of North Carolina.

2. That final judgment in this matter be reserved, until such time as the North Carolina State Board of Dental Examiners may have had further opportunity to inform itself as to the professional conduct and attitude of the accused; and that pending such final decision of this Board, the accused shall retain his license and be permitted to engage in the practice of his profession, subject at all times however, to further and final action by this Board.

Mr. J. B. Vaught, a laboratory technician of Wilmington, N. C., charged with practicing dentistry without license, was prosecuted and found guilty in the Recorders Court of Wilmington on April 6, 1933. A fine of two hundred, fifty dollars ($250.00) was imposed, payment being suspended for two years upon condition that the defendant remain of good behavior. No further complaints have reached this office.

At the annual meeting of the North Carolina Dental Society at Chapel Hill, N. C., Dr. W. F. Bell of Asheville was elected member of the Board to succeed Dr. D. E. McConnell of Gastonia and Dr. R. F. Jarrett of Charlotte, to succeed Dr. S. B. Bivens, deceased. These new members were duly commissioned by Governor J. C. B. Ehringhaus.

The fifty-third annual meeting of the North Carolina State Board of Dental Examiners for the purpose of examining applicants was held in Raleigh on June 26, 27, 28 and 29, 1933, all members being present, President J. A. McClung, presiding.

Thirty-one applicants having complied with the requirements of the Board were declared qualified and were permitted to take the examinations. Written examinations were held in the State Capitol Building; the clinical work at the State Prison.

At this meeting Dr. J. A. McClung was reëlected President and Dr. E. B. Howle, Secretary-Treasurer.

A special meeting of the North Carolina State Board of Dental Examiners was held at the King Cotton Hotel in Greensboro on Saturday, July 15, 1933, at 7:00 o'clock p.m., for the purpose of tabulating grades. All members were present, President John McClung, presiding.

Of the thirty-one applicants who had been permitted to take the examinations, license was issued to the following who were adjudged competent to practice dentistry in this State, having made a grade of eighty or more:

Allen, Howard L.	Henderson, N. C.
Black, Vance A.	Mt. Holly, N. C.
Burkes, Olive L. (Col.)	Edenton, N. C.
Byerly, Robert T.	Cooleemee, N. C.
Douglass, James D. (Col.)	Charlotte, N. C.
Eatman, Charles D.	Bailey, N. C.
Eatman, Edward L.	Bailey, N. C.
Fowler, William M.	Atlanta, Ga.
Hinton, Walter R., Jr.	Greensboro, N. C.
Hunt, Robert N.	Lexington, N. C.
Kiser, John D.	Charlotte, N. C.
Mackie, Edward B.	Granite Falls, N. C.
Marks, Sandy C.	Acme, N. C.
Matheson, William M.	Mt. Gilead, N. C.
Oliver, William T.	Chatham, Va.
Price, George W.	Whitakers, N. C.
Reece, John P.	Lenoir, N. C.
Telfer, Alex M.	New York, N. Y.
Turbyfill, William J.	Waynesville, N. C.
Weeks, Hemmeter E.	Tarboro, N. C.
Yokeley, Gilbert W.	Winston-Salem, N. C.

The following failed:

Baynes, Phillip S.	Roxboro, N. C.
Boykin, Alonzo E. (Col.)	Raleigh, N. C.
Crotts, Hylton K.	Winston-Salem, N. C.
Erbesfield, Morris	Newton, N. C.
Goodwin, Carey J.	Apex, N. C.
Moore, Maurice N.	Graham, N. C.
MacLean, John	Pelzer, S. C.
McMillin, C. D.	Compobello, S. C.
Teague, Everette R.	Madison, N. C.
Webster, Benjamin R.	Madison, N. C.

Attached hereto is the financial statement from January 1, 1934, as compiled by the Secretary-Treasurer, Dr. E. B. Howle and audited by R. C. Carter and Company certified public accountants of Raleigh, N. C., showing a balance in the Wachovia Bank and Trust Company of Raleigh, of two hundred, fourteen dollars and fifty-three cents ($214.53).

Attention is called to the unpaid balance in the closed Commercial National Bank of Raleigh of two hundred, ninety-two dollars and ninety-four cents ($292.94). It is expected that a part of this may be recovered.

Respectfully submitted,

E. B. Howle, *Secretary-Treasurer.*

DR. E. B. HOWLE, *Secretary-Treasurer,*
North Carolina State Board of Dental Examiners,
Raleigh, North Carolina.

DEAR SIR:

We have made an audit of the cash receipts and disbursements of the North Carolina State Board of Dental Examiners, Raleigh, North Carolina, from January 1, 1933, to December 31, 1933, and submit herewith our report.

We traced all recorded cash receipts into bank deposit, and found all cash disbursements supported by invoices and properly signed and canceled bank checks.

Respectfully submitted,
R. C. CARTER & COMPANY,
Certified Public Accountants.

February 27, 1934.

NORTH CAROLINA STATE BOARD OF DENTAL EXAMINERS
Raleigh, North Carolina

CASH RECEIPTS AND DISBURSEMENTS

From January 1, 1933, to December 31, 1933

Balance January 1, 1933:			
Commercial National Bank, closed		$ 292.94	
Wachovia Bank and Trust Company		214.53	$ 507.47
RECEIPTS			
Licenses	826 @ $ 1.00	$ 826.00	
Examination Fees	31 @ 20.00	620.00	
Penalties	24	151.00	
Reinstatements	1 @ 10.00	10.00	
Certificates	2 @ 5.00	10.00	$ 1,617.00
Total			$ 2,124.47
DISBURSEMENTS			
Per Diem and Expenses:			
Carr, Dr. H. C.	$ 60.98		
Howle, Dr. E. B.	54.48		
McClung, Dr. J. A.	74.23		
McConnell, Dr. D. E.	81.73		
Minges, Dr. C. E.	61.13	$ 332.55	
Salary, Secretary and Assistant		$ 200.00	
Postage, Stationery, Printing, etc.		325.96	
Examination Expense		175.25	
Attorney's Fees		64.05	
Audit		25.00	
National Association Dues		25.00	
Luncheons		5.00	
Taxes on Checks		1.28	

Flowers	$ 10.50	
Refunds	2.00	
Cost in Owens Case	438.26	$ 1,604.85
Balance:		
Commercial National Bank, closed	$ 292.94	
Wachovia Bank and Trust Company	226.68	
Total		$ 2,124.47

Dr. J. H. Wheeler, Chairman, Resolutions Committee offered the following resolution, which was unanimously adopted:

"After due consideration, of the many phases of collective bargaining by dentists with industry or other groups, and in view of the fact that collective bargaining has a tendency to establish prices and to lower the standard of the profession and of placing the profession of dentistry on a par with trade unions;

"*Be it Resolved*, that it is the sense of the North Carolina Dental Society that it is opposed to collective bargaining in any form by any group of dentists, or by any individual dentist, except when and if approved by the said North Carolina Dental Society."

Dr. F. O. Alford, Chairman, Publicity Committee, presented the following report, which was unanimously adopted:

PUBLICITY COMMITTEE REPORT

Your Publicity Committee wishes to submit the report as follows:

We were again this year fortunate in securing the services and coöperation of Mr. R. W. Madry and the University News Bureau, to them we are indebted for the publicity we have received this year.

During the Mouth Health Survey, we used pictorial publicity for all State papers. County papers were covered by Doctor Branch's department from Raleigh.

Beginning in February, several dispatches were sent through the Associated Press and United Press. Two months ago, Mr. Madry begun with his articles through the University News Bureau, which covers forty-five morning and afternoon papers throughout the State. Two three-column cuts and one one-column cut have been sent to all of these papers, together with twelve articles.

The meetings have been adequately covered by Mr. Madry, who is here as our guest, for both local and State press.

The committee wishes to express their sincere appreciation to Mr. Madry, the University News Bureau, the Associated and United Press, and the newspapers throughout the State for their coöperation.

Dr. L. M. Edwards, Chairman, Membership Committee, presented the following report, which was unanimously adopted:

MEMBERSHIP COMMITTEE REPORT

Your committee wishes to report as follows:

First District

Members in good standing	93
For suspension	4
Reinstated 1934	21
New members	6

Second District

Members in good standing	134
For suspension	10
Reinstated 1934	13
New members	6

Third District

Members in good standing	96
For suspension	7
Reinstated	7
New members	3

Fourth District

Members in good standing	84
Suspended	15
New members	2

Fifth District

Members in good standing	80
Reinstated	6
New members	3

The Secretary read the following telegram:

Dr. D. L. Pridgen, State Dental Society, Wilmington, North Carolina. Deeply appreciate your telegram. Am proud of Dental Profession. It has stood for a progressive constructive program and has rendered the Commonwealth outstanding service. Wish for your association a pleasant and profitable session. James M. Parrott. (Applause.)

Dr. Ralph Little, Chairman, Clinic Board of Censors, made the following report, which was unanimously adopted:

The Clinic Board of Censors wishes to commend most highly the North Carolina Dental Society clinicians, and to recommend to the American Dental Association the following clinics:

Dr. A. Pitt Beam, "Periodontal Treatment for the General Practitioner."

Dr. J. R. Bell, "Manipulation of Amalgam from a Practical Standpoint."

Dr. G. Fred Hale, "Some Etiological Factors in Mal-Occlusion and Oral Deformities."

The Secretary announced that he would like the privilege of filing at a later date list of members with one year in arrears on January 1, 1934. This request was granted by the chair.

MEMBERS IN ARREARS

First District

Carl Hardin	H. M. May

Second District

W. L. Cripliver	C. U. Voils
T. D. Morse	V. V. Voils

Third District

A. J. Adams	H. A. Karesh
P. Y. Adams	F. H. Underwood

Fourth District

W. E. Campbell	George Dennis

Fifth District

None

These members were one year in arrears on January 1st, 1934, and are therefore subject to suspension. However, from past experiences, we have reasons to believe that some of them may yet be induced to pay up. We therefore request that we be granted an extension of thirty days in which to make a final appeal to them, and that your Secretary-Treasurer be permitted to furnish the Editor-Publisher with a corrected list at the end of that time for publication in the proceedings.

We wish further to report that Dr. J. S. Wells of Reidsville and Dr. J. M. Neel of Salisbury have paid annual dues for twenty-five consecutive years, and are therefore admitted to Life Membership.

Respectfully submitted,

D. L. Pridgen, *Secretary-Treasurer.*

The House of Delegates was then adjourned and the General Session resumed its business.

President Branch:

I am going to ask Doctor Howle and Doctor McClung and Bob Olive to escort the new President to the chair. (Much applause.) Doctor Edwards, it is with great pleasure that I welcome you into this job.

President Edwards:

I thank you, fellow members. We will just proceed to the matters that we have in hand and close up this meeting.

I notice that the Vice-President is not in the room; we will have to pass that up for the present.

We will go to the installation of the Secretary-Treasurer, Doctor Pridgen. I will ask Doctor Olive and Doctor Lineberger to escort him to the chair. It is a pleasure for me to have you and I think I am extremely fortunate in having you as our Secretary-Treasurer. (Applause.)

Dr. D. L. Pridgen:

Thank you very much; I will do my best.

President L. M. Edwards:

I will now ask Dr. Henry Carr and Doctor Poindexter to bring Dr. Z. L. Edwards forward, our President-Elect. Doctor Edwards, I think the Society has shown extreme wisdom in selecting you for this very worthy office. I believe it is a selection that will greatly benefit the Society. I am mighty glad to have you. (Applause.)

Now the presentation of the two members of the Board of Dental Examiners, Doctor Howle and Doctor Poindexter. Doctor Alford and Doctor Johnson will bring Doctor Howle forward. Doctor Edwards and Doctor Minges will now bring Doctor Poindexter forward. I am very greatly pleased to recognize you both as members of a very important post. I feel that the Society is extremely fortunate in selecting you two. (Applause.)

It was unanimously carried that the following committees as selected by the President be affirmed:

COMMITTEES—1934-1935

EXECUTIVE COMMITTEE

Paul E. Jones, *Chairman* (1937) ..... Farmville
R. M. Olive (1935) ..... Fayetteville
Neal Sheffield (1936) ..... Greensboro

PROGRAM-CLINIC COMMITTEE

D. L. Pridgen, *Chairman* ..... Fayetteville
E. B. Howle, *Vice-Chairman* ..... Raleigh
D. F. Keel ..... Greensboro
H. L. Keith ..... Wilmington
A. S. Bumgardner ..... Charlotte
J. A. Sinclair ..... Asheville

Ethics Committee

J. N. Johnson, *Chairman*.....Goldsboro
J. Martin Fleming.....Raleigh
F. L. Hunt.....Asheville

Legislative Committee

J. N. Johnson (1937).....Goldsboro
F. O. Alford (1939).....Charlotte
E. B. Howle (1935).....Raleigh
Paul E. Jones (1936).....Farmville
H. O. Lineberger (1938).....Raleigh

Oral Hygiene Committee

E. A. Branch, *Chairman*.....Raleigh
E. M. Medlin.....Aberdeen
Cecil A. Pless.....Asheville
J. W. Whitehead.....Smithfield
Arthur Wooten.....Greenville

Librarian

Jessie L. Zachary.....Raleigh

State Institutions Committee

W. W. Rankin, *Chairman*.....Raleigh
J. S. Betts.....Greensboro
A. S. Bumgardner.....Charlotte
O. L. Presnell.....Ashboro
W. T. Ralph.....Belhaven

Military Committee

H. O. Lineberger, *Chairman*.....Raleigh
B. F. Paul.....Asheville
T. A. Wilkins.....Gastonia
A. M. Schultz.....Greenville

Liability Insurance Committee

J. H. Wheeler, *Chairman*.....Greensboro
J. P. Jones.....Chapel Hill
G. A. Lazenby.....Statesville
H. V. Murray.....Burlington

Membership Committee

Z. L. Edwards, *Chairman*.....Washington
C. S. McCall.....Forest City
D. W. Holcomb.....Winston-Salem
J. T. Lasley.....Greensboro
L. J. Moore.....St. Pauls
W. L. Hand.....New Bern

Exhibit Committee

D. L. Pridgen, *Chairman*.....Fayetteville
Paul Fitzgerald.....Greenville
N. P. Maddux.....Asheville
W. F. Clayton.....High Point
Dewey Boseman.....Wilson

Dental College Committee

H. O. Lineberger, *Chairman*.....Raleigh
H. E. Story.....Charlotte
E. P. McCutcheon.....Durham
Junius C. Smith.....Wilmington

Clinic Board of Censors

Clyde Minges, *Chairman*.....Rocky Mount
A. D. Abernathy.....Granite Falls
W. D. Gibbs.....Charlotte
L. G. Coble.....Greensboro
W. F. Mustain.....Warrenton
J. F. Coletrain.....Zebulon

Resolutions Committee

J. H. Wheeler, *Chairman*.....Greensboro
A. C. Current.....Gastonia
Ralph Jarrett.....Charlotte
Lee Roy Thompson.....Winston-Salem
D. K. Lockhart.....Durham
G. Fred Hale.....Raleigh
A. T. Jennette.....Washington

Necrology Committee

P. E. Horton, *Chairman*.....Winston-Salem
I. R. Self.....Lincolnton
T. Edgar Sikes.....Greensboro
Wilbert Jackson.....Clinton
R. M. Squires.....Wake Forest
H. L. Keith.....Wilmington
Clyde Minges.....Rocky Mount
John R. Pharr.....Charlotte
H. C. Carr.....Durham

Carolina-Virginia Clinic Committee

H. E. Story, *Chairman*.....Charlotte
M. D. Massey.....Greenville
W. F. Mustain.....Warrenton
L. J. Meredith.....Wilmington
J. T. Lasley.....Greensboro
N. P. Maddux.....Asheville
A. P. Beam.....Shelby

Committee on Entertainment of Visitors

Dennis F. Keel, *Chairman*.....Greensboro
J. A. McClung.....Winston-Salem
D. B. Mizzell.....Charlotte
Neal Sheffield.....Greensboro
R. M. Olive.....Fayetteville
O. L. Wilson.....Kinston

Publicity Committee

F. O. Alford, *Chairman*.....Charlotte
S. E. Moser.....Gastonia
Fred Campbell.....Hickory
P. P. Yates.....Lenoir
W. F. Bell.....Asheville
R. A. Little.....Asheville

Entertainment Committee

Carl Mott, *Chairman*.....Morganton
J. P. Reece.....Valdese
D. S. Cook.....Lenoir
J. M. Gaither.....Boone
C. B. Yount.....Hickory
Fred Campbell.....Hickory

Golf Committee

D. S. Cook, *Chairman*.....Lenoir
W. J. Miller.....Lenoir
Carl Mott.....Morganton

General Arrangements Committee

J. F. Reece, *Chairman*.....Lenoir
A. D. Abernathy.....Granite Falls
P. P. Yates.....Lenoir
Ralph Coffey.....Morganton
O. L. Moore.....Lenoir

Extension Course Committee

E. B. Howle, *Chairman*.....Raleigh
J. N. Johnson.....Goldsboro
Dennis F. Keel.....Greensboro
A. H. Fleming.....Louisburg
T. P. Williamson.....Charlotte

Committee on Relations of Physicians and Dentists

J. Martin Fleming, *Chairman*.....Raleigh
O. L. Presnell.....Ashboro
E. B. Howle.....Raleigh
G. Fred Hale.....Raleigh
J. N. Johnson.....Goldsboro

SUPERINTENDENTS OF CLINIC COMMITTEE

Harry Keel, *Chairman*.....Winston-Salem
J. A. Sinclair.....Asheville
A. C. Current.....Gastonia
C. C. Bennett.....Asheville
P. P. Yates.....Lenoir
R. E. Spoon.....Winston-Salem

EDITOR-PUBLISHER

G. Fred Hale.....Raleigh

SOCIO-ECONOMIC COMMITTEE

G. Fred Hale, *Chairman*.....Raleigh
Z. L. Edwards.....Washington
J. N. Johnson.....Goldsboro
E. B. Howle.....Raleigh
F. L. Hunt.....Asheville
Paul Jones.....Farmville
J. M. Fleming.....Raleigh
O. L. Presnell.....Asheboro
C. C. Bennett.....Asheville
F. O. Alford.....Charlotte

It was moved, seconded, and unanimously carried that the meeting adjourn.

The meeting then, at 12:45 p.m., Wednesday, June 20, 1934, adjourned.

MEMBERS OF THE NORTH CAROLINA DENTAL SOCIETY IN GOOD STANDING

FIRST DISTRICT

*A. D. Abernathy.....Granite Falls
W. R. Aiken.....Asheville
L. P. Baker.....Kings Mountain
*O. C. Barker.....Asheville
*A. P. Beam.....Shelby
E. N. Biggarstaff.....Spindale
*W. F. Bell.....Asheville
*C. C. Bennett.....Asheville
A. W. Bottoms.....Canton
A. V. Boyles.....Dallas
*J. F. Campbell.....Hickory
W. W. Carpenter.....Hendersonville
H. H. Carson.....Hendersonville
*W. K. Chapman.....Sylva
W. E. Clarke.....Asheville
A. P. Cline.....Canton

R. D. Coffey.....Morganton
*E. W. Connell.....Mount Holly
D. S. Cook.....Lenoir
D. H. Crawford.....Marion
E. M. Cunningham.....Biltmore
*A. C. Currant.....Gastonia
F. W. Davis.....Asheville
J. E. Derby.....Tryon
B. A. Dickson.....Marion
*H. C. Dixon.....Shelby
A. C. Edwards.....Lawndale
Geo. J. Evans.....Asheville
P. R. Falls.....Gastonia
H. O. Froneberger.....Bessemer City
J. M. Gaither.....Boone
*S. P. Gay.....Waynesville
E. R. Gilbert.....Highlands
B. F. Hall.....Asheville
S. J. Hamilton.....Burnsville
C. H. Harrell.....Lincolnton
O. H. Hester.....Hickory
F. B. Hicks.....Hickory
C. Highsmith.....Gastonia
L. J. Hooper.....Asheville
J. S. Howell.....Morganton
R. R. Howes.....Forest City
*F. L. Hunt.....Asheville
J. H. Hutchins.....Marshall
*A. A. Lackey .....Fallston
O. P. Lewis.....Kings Mountain
J. B. Little.....Hickory
*R. A. Little.....Asheville
E. B. Mackie.....Granite Falls
N. P. Maddux.....Asheville
L. H. Mann.....Asheville
J. A. Marshburn.....Black Mountain
N. M. Medford.....Waynesville
W. J. Miller.....Lenoir
O. L. Moore.....Lenoir
O. S. Moore.....Mount Holly
S. E. Moser.....Gastonia
C. B. Mott.....Asheville
Matt McBrayer.....Rutherfordton
Chas. S. McCall.....Forest City
D. E. McConnell.....Gastonia
C. H. McCracken.....Asheville
W. J. McDaniel.....Rutherfordton
W. P. McGuire.....Sylva
*G. C. Nichols.....Sylva
J. R. Osborne.....Shelby
J. M. Parker.....Asheville

Geo. K. Patterson.....Asheville
C. M. Peeler.....Shelby
Hugh S. Plaster.....Shelby
Cecil A. Pless.....Asheville
Ralph Ray.....Gastonia
*W. C. Raymer.....Newton
*John F. Reece.....Lenoir
J. P. Reece.....Valdese
H. L. Robertson.....Cliffside
I. R. Self.....Lincolnton
*Jas. A. Sinclair.....Asheville
S. H. Steelman.....Lincolnton
C. W. Stevens.....Hickory
Paul W. Troutman.....Hickory
B. C. Thomasson.....Bryson City
*R. C. Weaver.....Asheville
Evan S. Wehunt.....Cherryville
C. T. Wells.....Canton
J. L. West.....Franklin
T. A. Wilkins.....Gastonia
P. W. Winchester.....Morganton
P. P. Yates.....Lenoir
*J. A. Young.....Newton
C. B. Yount.....Hickory

SECOND DISTRICT

L. B. Albright.....Charlotte
*Geo. S. Alexander.....Kannapolis
*F. O. Alford.....Charlotte
T. I. Allen.....Charlotte
Fred J. Anderson.....Winston-Salem
R. P. Anderson.....Mocksville
*John L. Ashby.....Mount Airy
J. E. Banner.....Mount Airy
*Carl A. Barkley.....Winston-Salem
*J. R. Bell.....Charlotte
Grove C. Barnard.....Kannapolis
A. Mack Berryhill.....Charlotte
*J. P. Bingham.....Lexington
A. R. Black.....Charlotte
V. A. Black.....Charlotte
*C. A. Blackburn.....Winston-Salem
Daniel B. Boger.....Charlotte
I. A. Booe.....Mocksville
H. L. Brooks.....Monroe
*A. S. Bumgardner.....Charlotte
R. T. Byerly.....Winston-Salem
J. D. Carlton.....Salisbury
G. K. Carter.....Taylorsville
R. P. Casey.....North Wilkesboro
E. C. Choate.....Mocksville

E. G. Click.....Elkin
W. J. Conrad.....Winston-Salem
Vernon H. Cox.....Winston-Salem
R. W. Crews.....Thomasville
W. C. Current.....Statesville
*H. C. Daniel.....Salisbury
*V. L. DeHart.....Walnut Cove
S. C. Duncan.....Monroe
R. H. Ellington.....Salisbury
W. L. Ezzell, Jr.....Concord
P. L. Feezor.....Lexington
J. M. Folger.....Dobson
Burke W. Fox.....Charlotte
*R. A. Frye.....Pilot Mountain
*W. D. Gibbs.....Charlotte
J. H. Guion.....Charlotte
E. S. Hamilton.....Charlotte
R. B. Harrell.....Elkin
*A. P. Hartman.....Winston-Salem
J. F. Hartness.....Mooresville
Frank K. Haynes.....Charlotte
Gary Heeseman.....Charlotte
*H. R. Hege.....Mount Airy
H. C. Henderson.....Charlotte
*L. O. Herring.....Charlotte
*O. R. Hodgin.....Thomasville
*D. W. Holcomb.....Winston-Salem
J. M. Holland.....Statesville
*R. H. Holliday.....Thomasville
*P. E. Horton.....Winston-Salem
H. H. Houck.....Pineville
W. C. Houston.....Concord
*Geo. C. Hull.....Charlotte
P. C. Hull.....Charlotte
*R. Nat Hunt.....Lexington
Wm. A. Ingram.....Monroe
*Ralph F. Jarrett.....Charlotte
*F. G. Johnson.....Lexington
W. F. Jones.....Wilkesboro
O. L. Joyner.....Kernersville
*H. L. Keel.....Winston-Salem
J. L. Keerans.....Charlotte
Cyrus Clifton Keiger.....Charlotte
V. B. Kendrick.....Charlotte
Z. V. Kendrick.....Charlotte
W. L. Kibler.....Charlotte
F. W. Kirk.....Salisbury
*J. D. Kiser.....Charlotte
*A. R. Kistler.....Monroe
*G. L. Krueger.....Charlotte
G. A. Lazenby.....Statesville

Sam Levy.....Charlotte
W. C. Logan.....Winston-Salem
J. G. Marler.....Yadkinville
Guy M. Masten.....Winston-Salem
Robert Masten.....Winston-Salem
W. M. Matheson.....Charlotte
*R. P. Melvin.....Winston-Salem
F. C. Mendenhall.....Winston-Salem
*D. B. Mizell.....Charlotte
D. O. Montgomery.....Statesville
E. D. Moore.....Charlotte
E. B. Morgan.....Concord
Rosebud Morse.....East Bend
*J. A. McClung.....Winston-Salem
J. M. Neel.....Salisbury
J. H. Nicholson.....Statesville
Eva Carter Nissen.....Winston-Salem
*C. M. Parks.....Winston-Salem
J. H. Parks.....Kannapolis
R. M. Patterson.....Concord
*H. R. Pearman.....Cooleemee
*F. N. Pegg.....Kernersville
R. E. Petree.....Charlotte
*J. R. Pharr.....Charlotte
*A. J. Pringle.....Lawsonville
R. L. Ramsay.....Salisbury
C. A. Reeves.....Sparta
R. L. Reynolds.....Lexington
W. M. Robey.....Charlotte
G. L. Ross.....Charlotte
*Heywood Ross.....Charlotte
W. A. Secrest.....Winston-Salem
*C. F. Smithson.....Charlotte
W. A. Sowers.....Lexington
*R. E. Spoon.....Winston-Salem
*H. E. Story.....Charlotte
*S. H. Strawn.....Marshville
*B. C. Taylor.....Landis
C. F. Taylor.....Charlotte
L. A. Taylor.....Winston-Salem
L. E. Taylor.....Charlotte
W. A. Taylor.....North Wilkesboro
*W. C. Taylor.....Salisbury
*C. L. Thomas.....Mount Airy
Lee Roy Thompson.....Winston-Salem
L. P. Trivette.....Mooresville
M. L. Troutman.....Kannapolis
R. D. Tuttle.....Winston-Salem
*C. H. Wadsworth.....Concord
D. T. Waller.....Charlotte
*J. C. Watkins.....Winston-Salem

G. E. Waynick.....Winston-Salem
I. M. Waynick.....Winston-Salem
B. H. Webster.....Charlotte
C. D. Wheeler.....Salisbury
T. P. Williamson.....Charlotte
*G. W. Yokeley.....Winston-Salem
*K. M. Yokeley.....Winston-Salem
*J. W. Zachary.....China Grove
J. W. Zimmerman.....Salisbury

THIRD DISTRICT

*C. A. Adams.....Durham
*J. S. Betts.....Greensboro
W. W. Bowling.....Durham
*J. D. Bradsher.....Roxboro
R. W. Brannock.....Burlington
*Daniel T. Carr.....Durham
*Henry C. Carr.....Durham
R. R. Clark.....Chapel Hill
*W. F. Clayton.....High Point
*L. G. Coble.....Greensboro
J. Cecil Crank.....Greensboro
*A. W. Craver.....Greensboro
*L. M. Daniels.....Southern Pines
*H. A. Edwards.....Greensboro
*L. M. Edwards.....Durham
*R. M. Farrell.....Pittsboro
*W. I. Farrell.....Troy
L. M. Foushee.....Burlington
H. K. Foster.....Greensboro
A. E. Frazier.....High Point
J. S. Frost.....Burlington
*J. M. Gardner.....Gibson
*F. E. Gilliam.....Burlington
*C. A. Graham.....Ramseur
J. J. Hamlin.....High Point
J. N. Hester.....Reidsville
*W. R. Hinton.....Greensboro
*R. H. Holden.....Durham
N. T. Holland.....Durham
J. E. Holt.....Greensboro
J. H. Hughes.....Roxboro
*J. H. Hurdle.....Mebane
A. H. Johnson.....Greensboro
*J. P. Jones.....Chapel Hill
*Dennis F. Keel.....Greensboro
*G. E. Kirkman.....Greensboro
*C. D. Kistler.....Randleman
*J. T. Lasley.....Greensboro
C. T. Lipscombe.....Greensboro
*D. K. Lockhart.....Durham

B. R. Long.....Greensboro
H. S. Long.....Graham
R. E. Long.....Roxboro
J. R. Meador.....Reidsville
*E. M. Medlin.....Aberdeen
*C. I. Miller.....Albemarle
J. S. Moore.....Reidsville
W. H. Moore.....Hillsboro
H. V. Murray.....Burlington
C. W. McAnally.....Madison
S. H. McCall.....Troy
*E. P. McCutcheon.....Durham
A. A. McDuffie.....Candor
*Gates McKaughan.....Kernersville
*W. R. McKaughan.....High Point
J. B. Newman.....Burlington
R. T. Nichols.....Rockingham
*Carl P. Norris.....Durham
L. G. Page.....Yanceyville
*H. M. Patterson.....Burlington
*D. R. Pitts.....High Point
*C. C. Poindexter.....Greensboro
*E. F. Pope.....Albemarle
*O. L. Presnell.....Asheboro
A. P. Reade.....Durham
E. E. Richardson.....Leaksville
*J. B. Richardson.....High Point
*G. R. Salisbury.....Ashboro
*J. C. Senter.....Albemarle
E. W. Shackleford.....Durham
S. W. Shaffer.....Greensboro
B. B. Shamberger.....Star
*Neal Sheffield.....Greensboro
*R. P. Shepard.....Southern Pines
*T. E. Sikes.....Greensboro
H. A. Smathers.....Greensboro
L. T. Smith.....Reidsville
*J. S. Spurgeon.....Hillsboro
A. R. Stanford.....Greensboro
*John Swaim.....Asheboro
C. H. Teague.....Greensboro
H. W. Thompson.....Hamlet
E. A. Troxler.....Greensboro
E. J. Tucker.....Roxboro
*J. T. Underwood.....Durham
R. L. Underwood.....Greensboro
J. S. Wells.....Reidsville
C. M. Wheeler.....Greensboro
*J. H. Wheeler.....Greensboro
*P. B. Whittington.....Greensboro
*R. A. Wilkins.....Burlington

B. W. Williamson.....Hamlet
*J. F. Williamson.....Wadesboro
*W. L. Woodward.....Sanatorium
*G. N. Yates.....Durham
L. H. Zimmerman.....High Point
L. R. Zimmerman.....High Point
*T. R. Zimmerman.....High Point

FOURTH DISTRICT

*C. E. Abernathy.....Raleigh
*H. L. Allen.....Henderson
R. T. Allen.....Lumberton
*B. L. Aycock.....Princeton
*C. D. Bain.....Dunn
*A. D. Barber.....Sanford
*J. B. Bardin.....Chadbourn
*V. E. Bell.....Raleigh
*R. M. Blackman.....Selma
Dexter Blanchard.....Raleigh
*S. L. Bobbitt, Jr.....Raleigh
*E. A. Branch.....Raleigh
W. H. Branch.....Raleigh
J. W. Branham.....Raleigh
E. H. Broughton.....Raleigh
*C. H. Bryan.....Apex
J. K. Bryan.....Oxford
J. R. Butler.....Dunn
L. E. Buie.....Lemon Springs
N. G. Carroll.....Raleigh
*H. R. Chamblee.....Raleigh
R. D. Clements.....Raleigh
*J. F. Coletrane.....Zebulon
*A. S. Cromartie.....Fayetteville
H. R. Cromartie.....Raeford
I. H. Davis.....Oxford
*J. R. Edwards.....Fuquay Springs
Paisley Fields.....Fairmont
S. J. Finch.....Oxford
*A. H. Fleming.....Louisburg
*J. Martin Fleming.....Raleigh
*C. G. Fuquay.....Coats
*R. F. Graham.....Rowland
*L. G. Hair.....Fayetteville
*G. Fred Hale.....Raleigh
C. C. Hatch.....Sanford
*J. B. Herndon.....Laurinburg
*W. T. Herndon.....Fayetteville
*G. L. Hooper.....Erwin
*S. Robt. Horton.....Raleigh
*E. B. Howle.....Raleigh
*I. H. Hoyle.....Henderson

E. W. Hunter.....Sanford
J. K. Hunt.....Jonesboro
J. H. Ihrie.....Wendell
*Wilbert Jackson.....Clinton
*J. A. Jernigan.....Dunn
J. C. Johnson.....Raleigh
K. L. Johnson.....Raleigh
*M. L. Johnson.....Whiteville
*R. S. Jones.....Warrenton
*J. H. Judd.....Fayetteville
*E. N. Lawrence.....Raleigh
*E. G. Lee.....Clinton
*H. O. Lineberger.....Raleigh
*W. T. Martin.....Raleigh
*L. M. Massey.....Zebulon
*W. J. Massey.....Smithfield
*L. J. Moore.....Saint Pauls
J. D. Muse.....Henderson
*W. F. Mustian.....Warrenton
*F. W. McCracken.....Sanford
H. McK. McDiarmid.....Raeford
S. R. McKay.....Lillington
W. L. McRae.....Red Springs
*R. M. Olive.....Fayetteville
W. J. Payne.....Clayton
*D. L. Pridgen.....Fayetteville
*J. M. Pringle.....Elizabethtown
W. W. Rankin.....Raleigh
*C. W. Sanders.....Benson
*E. L. Smith.....Raleigh
D. T. Smithwick.....Louisburg
*R. M. Squires.....Wake Forest
*R. W. Stephens.....Apex
*J. E. Swindell.....Raleigh
W. W. Taylor.....Warrenton
J. J. Tew.....Clayton
*M. F. Townsend.....Lumberton
*R. A. Turlington.....Clinton
*A. D. Underwood.....Raleigh
*S. R. Watson.....Henderson
*J. W. Whitehead.....Smithfield
*W. F. Yates.....Chadbourn
*T. L. Young.....Raleigh
J. R. Zachary.....Raleigh

Fifth District

*V. M. Barnes.....Wilson
*O. J. Bender.....Jacksonville
M. D. Bissett.....Wilson
*A. B. Bland.....Wallace
A. C. Bone.....Rocky Mount

*Dewey Boseman.....Wilson
*J. O. Broughton.....Wilmington
J. W. Brown.....Rich Square
*L. H. Butler.....Hertford
F. G. Chamblee.....Spring Hope
*H. W. Civils.....New Bern
*F. H. Coleman.....Wilmington
*R. C. Daniel.....Southport
*J. H. Dreher.....Wilmington
*D. W. Dudley.....Kinston
*J. F. Duke.....Washington
*L. J. Dupree.....Kinston
*A. C. Early.....Aulander
*J. R. Edmundson.....Wilson
*Z. L. Edwards.....Washington
*P. Fitzgerald.....Greenville
C. H. Geddie.....Goldsboro
E. C. Grady.....Elm City
S. W. Gregory.....Elizabeth City
W. S. Griffin.....Edenton
*W. L. Hand.....New Bern
M. M. Harris.....Elizabeth City
W. I. Hart.....Edenton
*Oscar Hooks.....Wilson
R. F. Hunt.....Rocky Mount
*A. T. Jeanette.....Washington
B. McK. Johnson.....Greenville
*C. B. Johnson.....New Bern
*J. N. Johnson.....Goldsboro
*W. H. Johnson.....Plymouth
*P. E. Jones.....Farmville
*H. L. Keith.....Wilmington
*J. M. Kilpatrick.....Robersonville
J. L. Leggett.....Hertford
A. C. Liverman.....Scotland Neck
A. R. Mallard.....Goldsboro
*S. E. Malone.....Goldsboro
*Sandy C. Marks.....Wilmington
*M. B. Massey.....Greenville
W. C. Mercer.....Williamston
*L. J. Meredith.....Wilmington
*Clyde E. Minges.....Rocky Mount
R. W. Moore.....Tarboro
*B. R. Morrison.....Wilmington
*W. E. Murphrey.....Roanoke Rapids
*M. T. McMillan.....Goldsboro
*H. E. Nixon.....Elizabeth City
*J. A. Oldham.....Wilmington
*W. T. Oliver.....Rocky Mount
*G. L. Overman.....Goldsboro

William Parker.....Elizabeth City
*Z. V. Parker.....New Bern
*G. E. Pigford.....Wilmington
*J. G. Poole.....Kinston
*S. D. Poole.....Goldsboro
*C. G. Powell.....Ahoskie
*G. W. Price.....Kinston
*W. T. Ralph.....Belhaven
*C. R. Riddick.....Ayden
*A. M. Schultz.....Greenville
*J. H. Smith.....Wilmington
*J. C. Smith.....Wilmington
M. R. Smith.....Harrellsville
*W. T. Smith.....Wilmington
*T. W. Smithson.....Rocky Mount
*Herbert Spear.....Kinston
*J. W. Stanley.....Wilmington
E. W. Tatum.....Mount Olive
*C. A. Thomas.....Wilmington
*J. E. L. Thomas.....Tarboro
*H. K. Thompson.....Wilmington
*R. L. Tomlinson.....Wilson
*R. S. Turlington.....Goldsboro
*J. V. Turner.....Wilson
*Ransey Weathersbee.....Wilmington
W. J. Ward.....Weldon
W. M. Ward.....Roanoke Rapids
E. R. Warren.....Goldsboro
J. F. West.....Roanoke Rapids
J. H. White.....Elizabeth City
A. P. Whitehead.....Rocky Mount
*R. L. Whitehurst.....Rocky Mount
*R. E. Williams.....Goldsboro
*O. L. Wilson.....Kinston
*A. L. Wooten.....Greenville
J. H. Yelverton.....Wilson
Wm. D. Young.....Snow Hill
*W. H. Young.....Burgaw

The above list corrected to July 25, 1934.
*Indicates members attending 1934 (Wilmington) meeting.
Total registration Wilmington meeting including visitors, 365.

DENTISTS LICENSED TO PRACTICE DENTISTRY IN NORTH CAROLINA AT THE OFFICIAL EXAMINATION HELD JUNE 25, 1934

*Abernethy, Andrew David, Jr.....Granite Falls, N. C.
*Barringer, Marshall Robert.....Conover, N. C.
*Britt, Wilson Fleetwood.....Severn, N. C.
*Byrd, Robert Theodore.....Linden, N. C.
*Caddell, Frederick Silver.....Elon College, N. C.
*Cash, Allan Heath.....Boiling Springs, N. C.
Erbesfield, Morris.....Newton, N. C.
*Falls, Ralph Lane.....Lawndale, N. C.
*Garriss, Marcus Alton.....Margarettsville, N. C.
*Glenn, Edmond Theodore.....Sugar Grove, N. C.
*Goodwin, Carey Jackson.....Swainsboro, Ga.
*Hewitt, Macon Halliburton, Jr.....Forest City, N. C.
*Martin, Ernest Lee, Jr.....Leaksville, N. C.
*Parker, Henry Clay, Jr.....Charlotte, N. C.
*Powell, Jordan Beale, Jr.....Franklin, Va.
*Richardson, Alexander Liles.....Leaksville, N. C.
Spencer, James Lawson.....Richmond, Va.
*Taylor, Preston Reeves.....Mount Holly, N. C.
Teague, Everette Reid.....Madison, N. C.
Walker, Bernard Newman.....Meridian, Miss.
Webster, Benjamin Richard.....Madison, N. C.
*Wharton, Richard Goode.....Ruffin, N. C.
*Zibelin, Cedric Vollers.....Wilmington, N. C.

*1934 Graduate.

ROLL OF LIFE MEMBERS, BY VIRTUE OF HAVING PAID DUES FOR TWENTY-FIVE CONSECUTIVE YEARS

First District

F. L. Hunt.....Asheville
J. B. Little.....Hickory
D. E. McConnell.....Gastonia
J. R. Osborne.....Shelby
J. M. Parker.....Asheville

Second District

J. E. Banner.....Mount Airy
J. D. Carlton.....Salisbury
E. G. Click.....Elkin
W. J. Conrad.....Winston-Salem
H. C. Daniel.....Salisbury
H. C. Henderson.....Charlotte
P. E. Horton.....Winston-Salem
J. G. Marler.....Yadkinville
J. M. Neel.....Salisbury

R. L. Ramsey.....Salisbury
W. M. Robey.....Charlotte
C. F. Smithson.....Charlotte
J. C. Watkins.....Winston-Salem

THIRD DISTRICT

J. S. Betts.....Greensboro
W. F. Clayton.....High Point
N. T. Holland.....Durham
C. T. Lipscombe.....Greensboro
D. K. Lockhart.....Durham
R. T. Nichols.....Rockingham
C. P. Norris.....Durham
E. E. Richardson.....Leaksville
L. T. Smith.....Reidsville
J. S. Spurgeon.....Hillsboro
E. J. Tucker.....Roxboro
J. S. Wells.....Reidsville
J. H. Wheeler.....Greensboro

FOURTH DISTRICT

R. T. Allen.....Lumberton
N. G. Carroll.....Raleigh
A. S. Cromartie.....Fayetteville
I. H. Davis.....Oxford
A. H. Fleming.....Louisburg
J. Martin Fleming.....Raleigh
J. H. Judd.....Fayetteville
F. W. McCracken.....Sanford
G. B. Patterson.....Fayetteville
R. M. Squires.....Wake Forest
R. W. Stephens.....Apex

FIFTH DISTRICT

O. J. Bender.....Jacksonville
J. H. Dreher.....Wilmington
J. R. Edmundson.....Wilson
Oscar Hooks.....Wilson
J. N. Johnson.....Goldsboro
S. E. Malone.....Goldsboro
W. T. Smith.....Wilmington
J. W. Stanley.....Wilmington
J. H. White.....Elizabeth City
J. H. Yelverton.....Wilson

INACTIVE LIST

L. V. Henderson.....Virginia
W. F. Maderis.....Charlotte
P. L. Pearson.....Apex
J. S. Hoffman.....Charlotte

PRESIDENTS OF THE SOCIETY SINCE ITS ORGANIZATION

1875-76.....*B. F. Arrington
1876-77.....*V. E. Turner
1877-78.....*J. W. Hunter
1878-79.....*E. L. Hunter
1879-80.....*D. E. Everett
1880-81.....*Isaiah Simpson
1881-82.....*M. A. Bland
1882-83.....*J. F. Griffith
1883-84.....*W. H. Hoffman
1884-85.....*J. H. Durham
1885-86.....J. E. Matthews
1886-87.....*B. H. Douglas
1887-88.....*T. M. Hunter
1888-89.....*V. E. Turner
1889-90.....*S. P. Hilliard
1890-91.....H. C. Herring
1891-92.....*C. L. Alexander
1892-93.....*F. S. Harris
1893-94.....*C. A. Rominger
1894-95.....*H. D. Harper
1895-96.....*R. H. Jones
1896-97.....J. E. Wyche
1897-98.....*H. V. Horton
1898-99.....C. W. Banner
1899-1900.....A. C. Liverman
1900-01.....E. J. Tucker
1901-02.....J. S. Spurgeon
1902-03.....*J. H. Benton
1903-04.....J. M. Fleming
1904-05.....*W. B. Ramsey
1905-06.....J. S. Betts
1906-07.....J. R. Osborne
1907-08.....*D. L. James
1908-09.....F. L. Hunt
1909-10.....J. C. Watkins
1910-11.....A. H. Fleming
1911-12.....P. E. Horton
1912-13.....*R. G. Sherrill
1913-14.....C. F. Smithson
1914-15.....J. A. Sinclair
1915-16.....I. H. Davis
1916-17.....*R. O. Apple
1917-18.....R. M. Squires
1918-19.....J. N. Johnson
1919-20.....W. T. Martin
1920-21.....J. H. Judd
1921-22.....W. M. Robey
1922-23.....S. R. Horton
1923-24.....*R. M. Morrow
1924 25.....J. A. McClung
1925-26.....H. O. Lineberger
1926-27.....B. F. Hall
1927-28.....E. B. Howle
1928-29.....I. R. Self
1929-30.....J. H. Wheeler
1930-31.....Paul E. Jones
1931-32.....Dennis Keel
1932-33.....Wilbert Jackson
1933-34.....Ernest A. Branch
1934-35.....L. M. Edwards

*Deceased.

HONORARY MEMBERS

Adair, R. B.....Atlanta, Ga.
Austin, J. L.....Chattanooga, Tenn.
Beadles, E. P.....Norfolk, Va.
Bear, Harry.....Richmond, Va.
Bland, C. A.....Charlotte, N. C.
Bogle, R. B.....Nashville, Tenn.
Byrnes, R. R.....Atlanta Southern Dental College, Atlanta, Ga.
Callahan, P. E.....McRae, Ga.
Carroll, Delia Dixon.....Raleigh, N. C.
Cason, W. L.....Athens, Ga.
Collins, Clara C.....Atlanta, Ga.
Cooper, George M.....Raleigh, N. C.
Cowerden, L. M.....Hot Springs, Va.
Cuthbertson, C. W.....Washington, D. C.

Dale, J. A.....Nashville, Tenn.
Eby, Joseph D.....54 East 62nd St., New York, N.Y.
Foster, S. W.....Atlanta Southern Dental College, Atlanta, Ga.
Goldberg, E. H.....Bennettsville, S. C.
Gorman, J. A.....New Orleans, La.
Hardin, W. R.....U. S. P. H., Atlanta, Ga.
Harrison, G. R.....Richmond, Va.
Hartzell, Thomas B.....716 Donaldson Bldg., Minneapolis, Minn.
Heatwole, T. O.....Baltimore, Md.
Hill, Thomas J.....Cleveland, Ohio
Howard, Clinton C.....Atlanta, Ga.
Howe, Percy R.....Boston, Mass.
Huff, M. D.....Candler Bldg., Atlanta, Ga.
Hughes, C. N.....Grant Bldg., Atlanta, Ga.
Johnson, H. H.....Macon, Ga.
Kelsey, H. L.....Baltimore, Md.
King, Otto U.....5 N. Wabash Ave., Chicago, Ill.
Lambert, W. E.....Atlanta, Ga.
Maves, T. W.....501 Donaldson Bldg., Minneapolis, Minn.
Malone, R. W.....U. S. Navy
Milner, H. A.....Aiken, S. C.
Moore, S. W.....Baltimore, Md.
Neil, Ewell.....Doctor's Bldg., Nashville, Tenn.
Netherlands, Frank.....Asheville, N. C.
Nodine, Alonzo M.....London
Price, Weston A.....8926 Euclid Ave., Cleveland, Ohio
Quattlebaum, E. G.....Columbia, S. C.
Rickert, U. Garfield.....Ann Arbor, Mich.
Ruhl, J. P.....New York, N. Y.
Russell, A. Y.....University of Maryland, Baltimore, Md.
Rutledge, B.....Florence, S. C.
Sheffield, L. Langdon.....Toledo, Ohio
Silverman, S. L.....Fourth Nat'l Bank Bldg., Atlanta, Ga.
Simpson, R. L.....Richmond, Va.
Summerman, D. H.....Philadelphia, Pa.
Smith, A. E.....Chicago, Ill.
Spratley, W. W.....Richmond, Va.
Star, E. L.....Philadelphia, Pa.
Stevenson, Albert H.....376 5th Ave., New York, N. Y.
Stewart, H. T.....New York, N. Y.
Stone, A. E.....Philadelphia, Pa.
Strickland, A. C.....Anderson, S. C.
Tench, R. W.....New York, N. Y.
Thompson, Webb.....Spartanburg, S. C.
Tileson, H. B.....Louisville, Ky.
Turner, C. R.....University of Pennsylvania, Philadelphia, Pa.
Visanska, S. A.....Atlanta, Ga.
Whitaker, J. D.....Indianapolis, Ind.
White, J. A.....Williamston, N. C.
Wooding, C. E.....Winston-Salem, N. C.
Wright, John B.....Raleigh, N. C.

TO

DR. EUGENE B. HOWLE,

Affectionately called "Gene"

Uncompromising in principle; indefatigable in work; inspiring in leadership; patient in determination; efficient in practice; loyal to his friends; and an honor to his profession and State.

THE BULLETIN

....of....

THE NORTH CAROLINA DENTAL SOCIETY

VOL. 18 | OCTOBER, 1934 No. 2
JANUARY, 1935 No. 3

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INVESTIGATE AND THEN PROPOSE

Within the last two or three years there has been a great deal said and written about socio-economics. Let us keep our feet on the ground and first make a careful study of this question before we begin to draw conclusions and propose remedies. A departure from any established custom or precedent should be recommended only after a sound analytical study has been made. It would be of questionable value to the healing professions and the public alike at this time to propose radical departures from our system of practice. You will note in this BULLETIN very excellent reports of committee work of the A. D. A. It appears that they are using excellent judgment and caution. You will note, also, in these reports that the A. D. A. and the A. M. A. are working together, and it is hoped that at an opportune time the fruits of their study and work will be available to the committees in the State Societies.

We use this medium for an exchange of good wishes from all of us to all of us for a Very Merry Christmas and a Happy New Year.

REMINDER: *A. D. A. Relief Fund—don't delay sending your contribution*

The Relief Fund: We are most thankful that many of us are able to contribute to this A. D. A. Relief Fund; we are greatly in sympathy with those who are so unfortunate, through no fault of their own, as to be receivers. The Raleigh Society again this year contributed 100 per cent to this Fund. There must be other local societies in the State that have done likewise. Let's have a report on them. CONTRIBUTE!

IN THE SUPREME COURT OF NORTH CAROLINA

Fall Term, 1934

In re Accusation Against Dr. J. E. Owen } No. 105

Appeal from *Pless, J.*, at June Term, 1934, of Buncombe. Reversed.

This was a proceeding instituted before the North Carolina State Board of Dental Examiners upon an accusation against Dr. J. E. Owen, a dentist licensed by the State, duly filed under the provisions of C. S., 6649, by Drs. Bennett, Little, and Wells, Dentists.

The accusation was heard and judgment entered by the Board of Dental Examiners, from which the respondent, Dr. J. E. Owen, appealed to the Superior Court. The case was transferred from Wake County to Buncombe County, where it was heard at term time upon an agreed statement of facts, and judgment was there entered revoking the license of the respondent to practice dentistry. From this judgment the respondent appealed to the Supreme Court, assigning errors.

Harry A. Gorson and Marcus Erwin for appellant.
Sale, Pennell & Pennell for appellees.

Schenck, J. The portion of the statute, C. S., 6649, as amended by chapter 270, Public Laws 1933, pertinent to the accu-

sation filed, reads: "Whenever it shall appear to the Board of North Carolina Dental Examiners that any licensed dentist practicing in the State has been guilty . . . of false notice, advertisement, publication, or circulation of false claims, or fraudulent or misleading statements of his art, skill, or knowledge, or of his method of treatment or practice, . . . or has by himself or another solicited professional business the board shall revoke the license of such person."

The accusation filed charges: (1) "That the said Dr. J. E. Owen has, since 18 June, 1933, by himself and by another, solicited professional business as a practitioner of dentistry by running paid advertisements, and/or solicitation for professional business in the *Asheville Citizen,*" and

(2) "That since 18 June, 1933, the said Dr. J. E. Owen has by himself, or another, solicited professional business by advertisements upon the buildings in the city of Asheville in which said Dr. J. E. Owen has his offices, said signs or advertisements soliciting professional business all being painted in yellow and black colors," and of large dimensions.

It will be noted that nowhere in the accusation is there any charge of false advertisement or publication, or of the circulation of any false claims or fraudulent or misleading statements. The charge is (1) that the respondent solicited professional business as a practitioner of dentistry by running paid advertisements in the newspapers, and (2) that he solicited professional business by signs in colors and of large dimensions upon the building in which he has his office.

In the agreed statement of facts upon which the case was heard in the Superior Court there is no mention of false advertisements or of circulation of false claims or fraudulent or misleading statements. In this statement it is agreed (1) that the respondent caused to be published in newspapers of large circulation paid

advertisements of his work and prices charged, and (2) that the respondent maintained on the outside of the walls of the building in which he had his offices certain signs, advertising his work and prices, painted yellow and black and of large dimensions.

The judgment below, entered upon the agreed facts, contains, *inter alia,* the following: ". . . The court being of the opinion that the respondent has by himself or others solicited professional business, as alleged in the accusation," and concludes by adjudging that "the judgment of the North Carolina State Board of Dental Examiners in this cause is affirmed, and the license to practice dentistry in the State of North Carolina, heretofore granted the respondent, Dr. J. E. Owen, be and is hereby revoked. . . ."

The respondent's appeal from the judgment of the Superior Court raises the question as to whether the insertion of paid advertisements of his work and prices by a licensed dentist in newspapers with a large circulation and by signs in flaring colors and of large dimensions constitutes such soliciting of professional business as is inhibited by the statute as amended. We think not.

The offenses against which the statute inveighs are (1) that of false advertising, and the circulation of false claims or fraudulent or misleading statements, and (2) that of soliciting professional business.

Advertising, or the circulation of statements, without the taint of falsity or fraud, either by newspaper or sign, although paid for, cannot be construed as a violation of the statute. Advertising and soliciting are not synonymous terms. If such were so, every dentist who inserted a professional card in a registry, directory, or other publication, and paid for such insertion, or who placed upon the window or door of his office, or upon the wall of the building in which his office is located, his name followed by the word "dentist," would subject himself to an accusation that might lead to the revocation of his license. We apprehend that such was not the

purpose of those who drafted the statute. The statute only makes the use of false advertising, or the circulation of fraudulent and misleading statements, unlawful, and the corollary follows that the use of truthful advertising and circulation of truthful statements are not unlawful. *Expressio unius est exclusio alterius.* There is no suggestion in the record of any soliciting by the respondent otherwise than by advertising in newspapers and by signs.

We do not pass upon the ethics of the advertising resorted to by the respondent in this case, but under the statute as drawn, in the absence of any allegation of falsity or fraud, we are constrained to hold that judgment below is erroneous. If the North Carolina Board of Dental Examiners desire to have further limited the nature and extent of advertising to which members of their profession may lawfully resort, their remedy lies with the Legislature and not the courts. The law-making branch of the Government, if in its wisdom it saw fit, might make unlawful any kind of advertising by members of the dental profession, whether false or otherwise, but as yet it has not done so.

In view of the foregoing, it does not appear that the enforcement of C. S., 6649, will result in injury to the respondent, and we are therefore not called upon to determine the constitutionality of the statute in this proceeding.

Reversed.

As stated in the above opinion, if dentistry would rid itself of the malignancy of advertising, a new law must be formulated. Such a law is imperative for the protection of the health of the people of our State.

The Legislative Committee of the North Carolina Dental Society is conducting an intensive study with a view to drafting a new law, or amendments to our present law, for presentation to the General Assembly which meets in Raleigh on January 8, 1935.

The enactment of these changes will entail a vast amount of work. It will not be a job for the Legislative Committee alone, but for the North Carolina Dental Society. Every member will have an opportunity to aid in this important work.

Your committee hereby solicits suggestions. Time is short; send them today.

Your Legislative Committee is composed as follows:

E. B. Howle, *Chairman;*
J. N. Johnson,
Paul Jones,
H. O. Linebergeb,
F. O. Alford.

FINE DISTRICT MEETINGS

Have recently returned from the First District Meeting at Rutherfordton and the inspiration gathered is still with me. The last three District Meetings came in such close succession that one could not lose enthusiasm from one to the other. The interest shown at these meetings and the great amount of work necessarily done to perfect them is most commendable. In all five districts a program was put on, a part of which would be a credit to a State Meeting, and in some cases would look well at the A. D. A. Another noticeable feature was the splendid attendance and the undivided interest shown by almost all in attendance, in the scientific papers and clinics and the discussions following. The air of seeking and understanding the best from each part of the scientific portion of program permeated each meeting.

I was particularly interested in the Rutherfordton meeting, as it was held in the section of the State that will be host to the State Meeting in June. Some of the officers of this District Society are on the State general arrangements, entertainment, golf, and other committees. After observing how harmoniously and enthusiastically they work up there, I have no fear in regard to the manner in which our State Meeting will be handled. They are anxious for a large attendance, and have promised untiring effort in making their part of the meeting at Blowing Rock a "howling" success. This is perhaps one of the most magnificent portions of Western Carolina and the scenery en route from any direction is of equal grandeur.

Now in regard to the part that induces most of you to attend these meetings: The papers and clinics. Your program committee has been diligently at work and has already secured acceptances from some of the most outstanding men in their respective lines. This committee will continue to function, revising and adding to, until a varied program of interest to every practitioner, something he can take back to his office and put into practice, has been perfected. In addition, the economic side as confronts our profession today will probably be briefly but concisely dealt with. This is your meeting and an effort is being made to give each one in attendance something of real interest.

The profession of dentistry is so rapidly changing into a more definite branch of preventive medicine that it behooves us all to keep abreast by studying, attending scientific meetings, and each one doing his part towards elevating the profession to a still higher plane. Wonderful strides have been made during the past decade, and even greater opportunities are open to us. This can only be accomplished by organized effort, and also by the same means only can we combat the phantom of outside influences, likely to undo some of the great work already achieved. Each of us is due to put back into the profession something in return for the benefits received, due to the work of the pioneers and the ones preceding us.

With the prospects of a splendid program, the getting together in a most delightful and comfortable spot, I urge you all to mark off June 17, 18, and 19 as soon as you receive your 1935 appointment books. Show to the various committees your appreciation for their faithful efforts, but most of all, derive the benefits to yourself as a result of their work.

L. M. Edwards, D.D.S.,
President of North Carolina Dental Society.

1935 PROGRAM

Your Program Committee is now concentrating on the selection of material for our next annual meeting at Blowing Rock. And while it is yet so early that we cannot give you a complete outline of the program, we are glad to be able to announce that the following nationally-known men will be with us:

Dr. Arthur B. Crane and Dr. Harry Kaplan, two of the most outstanding teachers and research workers of Washington, D. C.,

will jointly present the subject, "Pyorrhea Alveolaris." They have requested, and will be granted, ample time in which to fully cover their subject. And you may be assured that their discussion will be most comprehensive, interesting, instructive, and practical, all of which will lead up to the Crane-Kaplan Surgical Treatment. Their clinic will be adequately illustrated by means of models and lantern slides, and no general practitioner can afford to miss it.

Dr. Sidney S. Jaffe, another widely-known and popular clinician of the Capital City, will cover, in a series of illustrated lectures, Denture Prosthesis. The titles of his lectures will be, "A Technic for the Construction of Full Upper and Lower Dentures, Which Will Require No Corrections or Adjustments When Once Inserted," "Stabilization of Flat Lower Dentures"—that is, a lower denture which has to be constructed on a mandible where the ridge is completely obliterated—and "Immediate Dentures."

The committee feels that if it had nothing further to present on the program we should have a most successful meeting. However, we shall have other visiting clinicians, as well as some mighty good local clinicians.

A. D. A. Membership Contest

The attention of our members is called to the A. D. A. membership contest, which comes to a close for its first year on March 1, 1935. The factors which will figure in the rating for each state society will be the number of new members secured during the year, the number of members whose 1935 dues are paid by March 1, and the number of registered dentists practicing in the state. Each member may aid in giving the North Carolina Dental Society a good rating, first by paying 1935 dues promptly, so that they can be forwarded from the State Secretary's office not later than March 1, and second, by doing everything possible to get non-members to align themselves with us. Your coöperation is most earnestly solicited.

D. L. Pridgen,
Secretary-Treasurer.

CO-OPERATION

It is the desire of the Officers and Board of Trustees of the American Dental Association that a close relationship between the constituent societies and the parent body be maintained at all times. One of the channels through which this may be accom-

plished most effectively is by having the Trustee in the respective district appear upon the program of the state societies in his district and present to the membership matters of interest in regard to the activities of the national organization, and discuss with the officers and members current problems which may be both of local and national concern.

The members of the Board of Trustees have each expressed a willingness to coöperate in this plan and will be available for your state program.

May I suggest that your program be so arranged that twenty-five or thirty minutes can be devoted to a message from your Trustee, Dr. H. Bear, 410 Professional Building, Richmond, Va., and that you extend him an invitation to appear upon it.

Under the present arrangement the expenses will have to be borne by the state society. However, this in most cases will only be nominal and will, I am certain, be worth much more than the expenses incurred.

I need not tell you that unity of action and a greater solidarity of our organization is becoming progressively more important and more necessary each year. Therefore, may I sincerely request that your society assist in carrying out any plan which may prove of benefit to the members of our organization and to the profession at large.

You may be assured that I will be very glad to render any assistance that I can to your society during the tenure of my office, but I realize that we must all put our shoulders to the wheel and work faithfully, diligently, and unselfishly, if the best interests of all are to be served, progress maintained, and further accomplishments achieved.

With kind regards to you and the members of your society, I am

Yours sincerely,

(Signed) F. M. Casto,

President of the American Dental Association.

The American Dental Association carries on fourteen distinct endeavors, and lists them:

1. Publication of the Journal.
2. Annual Meetings.
3. Bureau of Public Relations.
4. Library Bureau.

5. Bureau of Chemistry.
6. Council on Dental Therapeutics.
7. Judicial Council.
8. Dental Educational Council.
9. Committee on Dental Indexing.
10. Committee on Dental Legislation and Correlation.
11. Relief Fund Commission.
12. Research Commission.
13. Committee on Dental Economics.
14. Group Insurance.

All of these are at the service of members day and night, and many of them benefit nonmembers equally as much. The nonmember should never forget that he is an extensive beneficiary of the Association, even if he ignores it.

DENTAL HEALTH EDUCATIONAL MATERIAL

ISSUED BY THE BUREAU OF PUBLIC RELATIONS,
AMERICAN DENTAL ASSOCIATION

"We wish to call our readers' attention to the list of Dental Health Educational Material printed on pages 2063 to 2071 of the Journal of the American Dental Association, November, 1934.

"Over fifty dental health articles are included in this list—pamphlets on mouth health, lectures, radio talks, pamphlets on nutrition, stories, plays and rhymes, dental programs, newspaper articles, posters, charts, motion-picture films, stereopticon slides, first-grade and fourth-grade dental educational leaflets, models, and booklets on the care of the teeth—all of this material is ethical, authentic, and interesting. Most of the newer material has been approved by the Dental Health Educational Committee of the American Dental Association and the United States Public Health Service.

"Refer to your November issue of the Journal of the American Dental Association, or write to the Bureau of Public Relations, American Dental Association, 212 E. Superior Street, Chicago, Illinois, for a complete list of dental health material."

ANNOUNCEMENTS

The Five-State Post-Graduate Clinic, The Wardman Park Hotel, Washington, D. C., May 18-19-20, 1935.

Midwinter meeting of the Chicago Dental Society, Stephens Hotel, Chicago, Ill., February 18-19-20-21, 1935.

APES, MEN, AND TEETH

Perhaps no outstanding general scientist has so forcefully presented the importance of teeth as Dr. Ernest A. Hooton, Professor of Anthropology at Harvard University, in an article, entitled "Apes, Men, and Teeth," in the January, 1934, issue of the *Scientific Monthly*. Dr. Hooton supplies the evidence that life on earth has risen and fallen in its evolution more directly through the teeth than any other part of the anatomy. In fact, he predicts the extinction of the human race unless we find some way of conserving the teeth. We recommend this fascinating article to every dentist, and especially to orthodontists, who may find it of particular interest. The following are extracts from the article. U. G. R.

Teeth tell the tale of human evolution better than any other bodily structure. No, I have not forgotten brains. But we do not understand the evolution of the human brain. Our brains are apparently much too big for the use we make of them. Certainly, neither we nor our immediate or remote ancestors have taken thought sufficiently to add many cubic centimeters to our cranial capacities. Yet here we are—all decked out in our 7¼ hats—and no place to go. We have less reason to be proud of our brains than to be ashamed of our teeth.

Teeth seem to be a distasteful subject for popular consideration. They are unpleasantly reminiscent of the apprehensive minutes spent in the dental waiting room with the futile distraction of back numbers of cheery periodicals—and other far worse experiences. Yet our teeth have had an illustrious past; they have a serviceable present, and with due conservation they will continue to perform an indispensable function in the future of man. But if the human dentition breaks down, it will carry with it in its fall the human species.

You must know the history of the teeth in order to appreciate them, and because this history epitomizes human evolution. The control of future human evolution is now in man's own hands—or perhaps rather in his teeth.

Short History of Teeth

Teeth are the most nearly imperishable relics of the vertebrate body. If an animal's teeth last until death, they will continue to defy the destructive action of time and the elements—sometimes for millions of years. After death the soft parts of the animal body decay rapidly. The bones are much tougher. But bones are frequently crushed into dust or dissolved by the action of chemicals in the earth. Furthermore, they are often and perhaps usually devoured by carnivorous animals for which they are a "bonne bouche." But teeth are singularly unpalatable and indigestible morsels. No animal eats them or, if it does, manages to digest them. They remain as monuments of extinct species.

This is particularly fortunate for the student of evolution, since the teeth are not only the most durable, but also the most instructive of bodily parts.

. . . . . .

How to Stop Dental Degeneration

In my opinion there is one and only one course of action which will check the increase of dental disease and degeneration which may ultimately cause the extinction of the human species. This is to elevate the dental profession to a plane upon which it can command the services of our best research minds to study the causes and seek for the cure of these dental evils. Such an improvement of the quality of the dental profession is an indispensable prerequisite for the attacking of these tremendous pathological and evolutionary problems. No effective measures of public education in care of the teeth can be taken until dental practitioners cease to be tinkers and learn to be scientists. In making such a statement I by no means wish to belittle the tremendous progress in the field of dentistry which has already been made.

As a matter of fact, if I were asked in what occupations the United States indubitably leads the world, I should reply without hesitation "Dentistry and plumbing." American dentists have reached a pitch of mechanical skill which is equal to that of American surgeons. But carpentry is not enough. Stopping teeth does not stop tooth decay. In the dental profession today are many brilliant scientific minds and many practitioners of consummate skill whose aims are humanitarian rather than pecuniary, but there are too few of such men and they have been insufficiently trained.

The dental profession has been for too long a time a neglected and disowned orphan child of medicine and surgery. While millions have been lavished upon medical schools and hospitals, and upon medical and surgical research, almost nothing has been allotted for these purposes to dentistry. Our schools of dentistry have been forced to struggle along without endowments; their teaching staffs have consisted almost entirely of devoted but unpaid men who give part of their time to teaching, but have to make their living in practice.

. . . . . .

The faculties of dental schools recognize these shortcomings and are striving to raise their standards and to transform dentistry from a trade to a profession, from a craft to a science. But they cannot succeed in any large measure until the public and the philanthropic foundations, and especially the medical profession itself, recognize the essential parity of dentistry with other branches of medical science.

. . . . . .

Read the article. U. G. R.

(Written for members of the American Association of Dental Editors.)

Dr. D. B. Mizell, who has recently been in the hospital in Baltimore for an operation on his leg, is now able to return to his office.

PROFESSIONAL SPIRIT

"Professional Spirit is the impulse that causes a man to give back to his profession more than he receives from it."

RALPH F. JARRETT.

"Professional Spirit should be a live, vital, and active force for the advancement of dentistry in all its branches, without petty jealousies and selfishness, having a broad understanding and sincere feeling for the welfare of our profession in that we all take a more active interest in the wonderful programs of our District and State Societies."

A. PITT BEAM.

"Do unto others as you would have them do unto you."

H. L. KEITH.

"That dentist best exemplifies the spirit of his profession who serves his patients with conscience and skill, and who, through research and practice, coöperates with others to promote oral hygiene and dental care, and to increase the beauty, health, and efficiency of the human race."

R. M. SQUIRES.

"See no evil, hear no evil, speak no evil."

J. MARTIN FLEMING.

"Doing what is right for client, profession, and fellow-practitioner."

WM. FORREST BELL.

"Professional Spirit, that sincere feeling toward our fellow-practitioners which unites us in the common cause."

E. M. MEDLIN.

Albert Einstein says, "Art creates what is not and science only discovers what already is."

A combination of these two, conscientiously studied, practiced, and unselfishly applied, so as to be of the greatest benefit to humanity and our patients is at least our sense of the professional spirit.

L. M. EDWARDS.

"Professional Spirit is cheerful willingness of ethical coöperation of a specialized service."

ROBT. M. OLIVE.

REMINDER: *A. D. A. Relief Fund—don't delay sending your contribution*

CONFERENCE ON SOCIAL SECURITY

On November 14, a meeting of the Committee on Social Security was held at the Mayflower Hotel in Washington, D. C.

This meeting was the outcome of the appointing by President Roosevelt, on June 9, of a committee headed by Frances Perkins, Secretary of Labor, and consisting of Attorney-General Cummings, Secretary of the Treasury Morganthau, Secretary of Agriculture Wallace, and Mr. Harry L. Hopkins, Federal Emergency Relief Administrator. The reason for appointing this committee was to make such studies and bring the results of their labors to President Roosevelt so that he might be properly advised as to what course should be pursued to bring to the people of the United States a greater degree of social security through the enactment of laws in the Congress of the United States.

It was further devised that an Advisory Committee of twenty be appointed, the chairman of which is Dr. Frank P. Graham, President of the University of North Carolina. In addition to this Advisory Committee, a number of technical advisory boards were appointed to advise the technical staff in the formulation of programs for the various activities decided to be followed by the committee.

The conference was called to order by the chairman of the committee at the Mayflower Hotel and, after a short session, was divided into discussion groups on the various subjects to be covered by the work of the conference. At 5 p.m. the delegates to the conference were addressed by the President at a reception in the White House.

The Dental Advisory Board appointed by Secretary Perkins, consisting of eleven members, is as follows: Dr. Frank M. Casto, President of the American Dental Association, Cleveland, Ohio; Dr. J. Ben Robinson, President American College of Dentists, Baltimore, Md.; Dr. L. M. S. Miner, Boston, Mass.; Alfred Walker, New York City, N. Y.; John T. Hanks, New York City, N. Y.; George A. Coleman, Philadelphia, Pa.; O. W. Brandhorst, St. Louis, Mo.; Herbert E. Phillips, Chicago, Ill.; J. T. O'Rourke, Louisville, Ky.; Roy Green, Sacramento, Calif.; Bissell Palmer, New York City, N. Y.

A CONFERENCE WITH A COMMITTEE OF THE AMERICAN MEDICAL ASSOCIATION

A most important step was taken during the meeting of the Ad Interim Committee held at the headquarters of the American Dental Association in Chicago, November 20 and 21, when for the first time in the history of the two health professions official committees met to formulate plans for closer coöperation.

Those present from the American Medical Association were: Dr. Olin West, Secretary, Chicago; Dr. Edward Carey, Dallas; R. G. Leland, Chicago; Austin Hayden, Chicago; and R. L. Sensenich, South Bend, Indiana.

The members of the Ad Interim Committee and the members of the Economics Committee of the American Dental Association were also present.

After a comprehensive discussion of all points that were raised by different members present, there prevailed a most cordial spirit among those present, and at the conclusion it was apparent that a much closer relation would undoubtedly be maintained in the future.

Dr. West, Secretary of the American Medical Association, placed at the disposition of the American Dental Association all of the resources of the Bureau of Economics of the American Medical Association.

This marks a new development in the progress of the health professions which undoubtedly will redound much to the benefit not only of the members of the profession but to the public as well.

THE COMMITTEE ON ECONOMICS FOR THE AMERICAN DENTAL ASSOCIATION MEETS

The following members of the Executive Committee of the Committee on Economics for the American Dental Association met in Chicago, November 20: Edward H. Bruening, Chairman, Omaha, Neb.; John T. Hanks, New York City; Harold W. Oppice, Chicago; and Lon W. Morrey, Chicago.

A report of the Washington conference was given by Dr. Hanks.

Dr. Kirby of the American Pharmacists' Association was present and asked for the coöperation of the American Dental Association with the American Pharmacists' Association, which is a body of professional pharmacists. He explained to the committee the aims of the association and several of their activities.

After careful consideration of the various subjects which came to a focus as the outcome of the Conference on Economic Security and the interest which has been displayed in reference to health insurance, the Economic Committee prepared the following resolution, which was presented to the Ad Interim Committee for their consideration:

> *The American Dental Association is opposed to the enactment of legislation along the lines of so-called compulsory health insurance until the health professions are thoroughly satisfied that the interests of the public and the professions are properly safeguarded.*

The Ad Interim Committee, after considering this resolution carefully, adopted it unanimously. Secretary Pinney of the American Dental Association has sent out an official communication to the state officers embodying this action.

MEETING OF THE DENTAL ADVISORY BOARD OF THE COMMITTEE ON ECONOMIC SECURITY

The Dental Advisory Board appointed by Secretary Perkins, chairman of President Roosevelt's Committee on Economic Security, which was called to advise with the committee's technical staff in its studies of the relation of dentistry to public health, dental care, and health insurance,

met in the Red Cross Building in Washington, D. C. The board met in executive session with all of the following members present: Dr. Frank M. Casto, President of the American Dental Association, Cleveland; Dr. J. Ben Robinson, President of the American College of Dentists, Baltimore; Dr. LeRoy M. S. Miner, Boston; Dr. Alfred Walker, New York City; Dr. John T. Hanks, New York City; Dr. George A. Coleman, Philadelphia; Dr. O. W. Brandhorst, St. Louis; Dr. Herbert E. Phillips, Chicago; Dr. J. T. O'Rourke, Louisville; Dr. Bissell Palmer, New York City; Dr. Roy Green, Sacramento, California.

There were present Edgar Sydenstricker, in charge of the medical and health studies of the Committee on Economic Security; also I. S. Falk, Nathan Siani, and Michael Davis, of the technical staff.

Edwin E. Witte, Executive Director of the Committee on Economic Security, made a short address at the opening meeting. He asked for the coöperation and advice of the dental members in assisting in developing the health aspects of the President's plan for economic security.

Because of the fact that the Dental Advisory Board will make its recommendations to the Committee on Economic Security, the matters under discussion at that time could not be made public, but we have been informed that the subject of lay education, questions of public health in which the dental profession is interested and the question of health insurance were discussed at that time.

The Dental Advisory Board decided to request Secretary Perkins to allow them more time in which to pursue their studeis.

It was also decided that it would undoubtedly be necessary for the Advisory Board to hold subsequent meetings, when these questions may be thoroughly discussed and the findings which are to be presented to the Committee for Economic Security decided upon.

[NOTE.—These four articles, dealing with economic and social problems, were released from the office of Dr. Lon W. Morrey, Secretary of the Economics Committee of the American Dental Association, for use in this periodical.—G. F. H.]

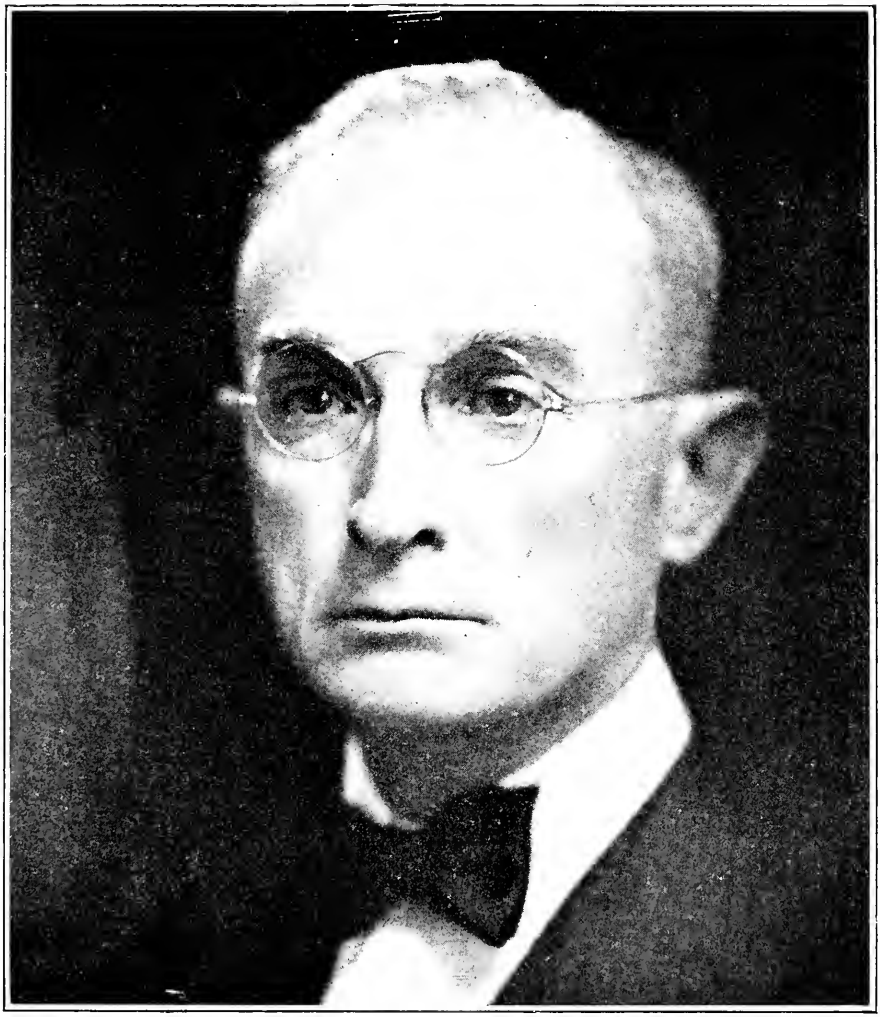
DEATHS

Mrs. Wallace F. Mustian, Warrenton, N. C., August 15, 1934, at Duke Hospital.

MARRIAGES

Dr. Heywood Ross, of Charlotte, was married August 30, 1934, to Miss Catherine Armour, of Charlotte.

"No dentist can," says G. V. Black, "under present conditions or the conditions that will probably prevail in the future, do himself or his community justice without becoming an active member of a dental society and taking an active part in its work."



James Marion Parrott, M.D.

North Carolina State Board of Health

January 7, 1874 November 7, 1934

DISTRICT SOCIETIES

DISTRICT OFFICERS AND DELEGATES, 1934-35

First District

President.....J. F. Reece, Lenoir
President-Elect.....O. C. Barker, Asheville
Vice-President.....S. E. Moser, Gastonia
Secretary-Treasurer.....Chas. S. McCall, Forest City
Editor.....A. D. Abernathy, Jr., Granite Falls
Delegates.....J. F. Reece, Lenoir; Chas. S. McCall, Forest City; C. B. Mott, Morganton; T. A. Wilkins, Gastonia; R. R. Howse, Forest City

Second District

President.....F. O. Alford, Charlotte
President-Elect.....J. H. Nicholson, Statesville
Secretary-Treasurer.....W. C. Current, Statesville
Editor.....T. P. Williamson, Charlotte
Delegates.....F. O. Alford, Charlotte; W. C. Current, Statesville; E. S. Hamilton, Charlotte; Harry Keel, Winston-Salem; D. O. Montgomery, Statesville

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President-Elect.....E. M. Medlin, Aberdeen
Vice-President.....C. D. Kistler, Randleman
Secretary-Treasurer.....C. A. Graham, Ramseur
Editor.....D. T. Carr, Durham
Delegates.....T. E. Sikes, Greensboro; E. M. Medlin, Aberdeen; C. A. Graham, Ramseur; J. H. Hurdle, Mebane; L. G. Page, Yanceyville

Fourth District

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Vice-President.....Everett L. Smith, Raleigh
Secretary-Treasurer.....L. J. Moore, St. Pauls
Editor.....R. M. Squires, Wake Forest
Delegates.....G. L. Hooper, Erwin; L. J. Moore, St. Pauls; J. R. Butler, Dunn; G. Fred Hale, Raleigh; R. M. Squires, Wake Forest

FIFTH DISTRICT

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President-Elect.....M. B. MASSEY, Greenville
Vice-President.....A. L. WOOTEN, Greenville
Secretary-Treasurer.....W. L. HAND, New Bern
Editor.....A. M. SCHULTZE, Greenville
Delegates.....PAUL FITZGERALD, Greenville
W. L. HAND, New Bern
Z. V. PARKER, New Bern
H. L. KEITH, Wilmington
FRED HUNT, Rocky Mount

SECOND DISTRICT

PRESIDENT'S ADDRESS

Winston-Salem, N. C., October 22, 1934

I wish to express my sincere appreciation for the honor and privilege of having served you as president for the past year. When you elected me to this office I felt that you had made an unwise selection. First, I felt that I did not deserve the honor; and secondly, that there were many other men who could do the work more efficiently than I. I am still of that opinion. However, with the help and coöperation of capable men on the various committees, we have tried to carry on in a manner in keeping with the high standard set by my predecessors. Whatever measure of success may come to the Society as a result of this year's work will not be due to any individual effort of mine, but rather to the combined efforts of the other officers and the men on these committees. They have worked hard, and when this meeting is over I am sure you will feel that their work has been a success.

In this brief message I would like to stress one particular thought, and that is the importance of membership in the organized dental society. During the past few years we have been in the midst of a world-wide economic depression which has left its mark on every business and every profession. The dental profession has not been excepted. As a result of this there has been a falling off in the membership of the organized dental society. Through the efforts of our President and the National Recovery Administration this year has been one of improvement. With this improved economic condition, let us strive to reënlist those old members who have dropped out and to interest every ethical nonmember in our District in becoming a member of this Society.

Perhaps the average dentist does not recognize or understand the benefits that the organization affords. I believe it is our duty as an organization to visualize to the nonmember the value of organized dentistry to him and to show him why he cannot afford to remain outside. It is true that for the most part the men who have kept pace with dental progress are members of the organized dental society.

On the other hand, the Society needs the help and coöperation of the nonmember just as much as he needs the Society. It is a mutual arrangement, with mutual good one to the other. With the suggestion of panel dentistry and with the different types of socialistic ideas prevalent for the past few years, we as a profession must stand more solidly together than ever before. The present-day trend of ever changing conditions is a challenge which must be met squarely and with a complete unity of purpose if our profession keeps step with the march of progress. These new plans and ideas cannot be met and correctly interpreted by the every-man-for-himself policy. It must be done as an organization. In union there is strength, and strength is needed to acquire the good as well as to oppose the bad.

I therefore urge you to make every effort during the coming year to contact every ethical nonmember in your community and secure his application for membership in this Society, by reinstatement or otherwise.

It is customary, I believe, for the retiring president to make recommendations in the interest of the future conduct and well-being of the Society. As you know, the Constitution and By-Laws have just been revised and will come up for ratification this afternoon. After reading it and studying it carefully, I commend it to you. I would also like to make the following recommendations:

First, that the Auditing Committee be abolished completely, since the books of the Secretary-Treasurer are audited by a Certified Public Accountant under the supervision of the Executive Committee.

And second, that in so far as is convenient and practical, the future meetings of this Society be alternated between the northern, central, and southern divisions of the District.

It has been a pleasure to have worked with you and for the Society during the past year. We have lived within our income and at the same time tried to give you a meeting equal to those in the past. During the past year we have reinstated sixteen (16) old members and had the addition of ten (10) new members. This District participated 100 per cent in the school survey in February. In my opinion this was a step toward making the children of our nation think more about mouth health. We should do more work along this line.

I would like to suggest that in the future we give more attention to preventing members in our community from becoming delinquent. I also suggest that we stress the value and meaning of life membership, explain more often how to obtain it, and impress it more forcibly on the membership.

In conclusion, I wish to thank all the other officers, the members of the different committees, and the entire membership for their splendid support and coöperation throughout the past year. I also wish to pledge my support to the incoming president, Dr. Alford. His record during two years as Secretary-Treasurer and this year as President-elect is commendable. May his association with you the coming year be as pleasant as mine has been during the past.

C. M. Parks, D.D.S.

OUTLINE OF CLINIC FOR INDIGENT CHILDREN FOR THE CITY OF CHARLOTTE

AGREEMENT WITH P.-T. A. COUNCIL OF CHARLOTTE

Each of the undersigned dentists, severally but not jointly, agrees to contribute, gratuitously, his professional services as a dentist one day a month from 9:00 a.m. to 1:00 p.m. in a dental clinic for *indigent* children, which said clinic for indigent children is to be arranged and operated by the Parent-Teacher Association Council of Charlotte, upon the distinct understanding and conditions that:

1. The clinic shall be established and operated in accordance with the laws of the State of North Carolina, and the city of Charlotte.

2. That neither of the undersigned dentists shall in any wise or in any sense, jointly or otherwise, be responsible for or liable for the acts, practice, or liability, or obligation of any other dentist, person, organization.

3. That all supplies, laundry, quarters, telephone, electricity, heavy equipment, water, stationery, secretary-assistant, etc., be provided or supplied without cost to or obligation on the part of either of the undersigned dentists.

4. That the undersigned dentists shall be known as the staff of the clinic, and shall have the right to supervise the professional conduct of the clinic.

5. That the Parent-Teacher Association Council be responsible for all financial liabilities and obligations.

6. That any of the undersigned dentists may, on giving fifteen days' written notice, resign from the staff of the dental clinic, and thereupon discontinue the contribution of his services to or for the clinic.

(Dr.) W. M. Robey is the director of this clinic.

Each case must be investigated by responsible agency, and report presented at time of application for service. (Use form similar to that used by school nurses, for tonsils, etc.)

By a teacher or principal in each elementary school.

By United Welfare Health Committee, P.-T. A., grammar and high school.

"Request for Service" blank must be signed by parent or guardian before service is rendered.

All expenditures must be authorized by P.-T. A. Dentist will be responsible for all expenditures made without such authority.

An advisory committee, composed of dentist in an advisory capacity and such members of the P.-T. A. as they see fit.

Record Cards—complete and accurate records must be kept of each case.

A monthly summary must be presented to both the P.-T. A. Council and staff.

No operation shall be attempted without necessary equipment or supplies.

REMINDER: *A. D. A. Relief Fund—don't delay sending your contribution*

INSTRUCTIONS TO NURSE

1. Post name of dentist on blackboard each morning.
2. Notify the dentist due for duty next day.
3. Notify the dentist due for duty in ten days.
4. Start appointment book each day with name of dentist reporting for duty and end with his signature approving the record for his day.
5. Make appointments at rate of about eight a day (subject to change).
6. Use First Ward School as a reserve call list to fill in when appointments are broken.
7. Make appointments in groups rather than individual, as four or five at 9 o'clock, four or five at 11 o'clock, etc.

In the beginning, use 15 minutes for a period, adjusting as experience dictates.

Crowd the work in the early hours, as emergency work is sure to appear.

Keep "Suggestion Book" on desk at all times for dentist to use. Its use will assist greatly.

The P.-T. A. School Dental Office has—
Mouth Mirrors,
Engine Instruments,
Hypodermic and Needles,
Supplies,
Towels,
Heavy Equipment.

Each dentist will furnish—
Plastic Instruments (own choice),
Extraction Instruments,
Scalers,
Coat.

THIRD DISTRICT

PRESIDENT'S ADDRESS

Southern Pines, N. C., November 9, 1934

It is with a feeling of a strange mixture of humility and pride that I arise to address you at this hour. Humility, arising from a keen sense of my unworthiness of the high office you have entrusted to me; but a pardonable pride in the dignity and distinction of that same high office, and in the confidence you have shown in me in bequeathing it. What I have been able to accomplish for the Society would not be enough to make a book. I will not even say that I've done all I could, for it is seldom any man does that. But one thing I can say truthfully, and that is my heart and best intentions have been with the Society, and from its creation as a district unit fourteen years ago it has been my constant ambition and controlling purpose to be one hundred per cent for it.

And speaking of beginning, in coming before you today I cannot refrain from being for just a moment a little reminiscent. Fourteen years ago, when the Third District was organized in Charlotte, N. C., the men present did not number over one dozen. The district unit system was then an untried experiment. No one knew whether it would prove a success or failure. Its beginnings indeed were feeble and there was no guarantee for the future; therefore, it was with a sort of fear and trembling that we launched and set out to seek a newer world; a newer and richer heritage for the noble profession of dentistry.

Another thing we had to borrow from Tennyson a little further, "We had one equal temper of heroic hearts, not particular made weak by time and fate, but nonetheless strong in will to strive, to seek, to find, and not to yield." We did have a vision, and a purpose, and that purpose was headed toward a greater progress, a higher development of the dental profession; a more sympathetic and coöperative spirit toward our fellow practitioners, to give greater scope for the unfolding of circumscribed genius, and thus bring to humanity a larger and more efficient service.

The fullness of that dream has, of course, not yet been realized. Perhaps it will not be even in the next dozen years; nevertheless, progress has been made—much progress is being made at the present. The membership has increased from a mere handful, as it were, to approximately one hundred. Papers have been read, clinics have been given, and useful ideas have been born and put to use that perhaps would never have seen the light if this organization had never been. Budding talent has been called from out the shadows and the sun of genius has been encouraged to rise and shine for the health and healing of the sons of men. We have gone far in these years, and I come now to utter a word of encouragement and consolation for the distance already covered; and then to add another word of encouragement that we carry on to higher and nobler fields. We have done much, but much remains to be done. These accomplishments cannot be attained single-handed. It will require active service of each and every one, and let me admonish you to not let up in spreading the good news until every dentist in the third district who is eligible to membership becomes a member of our Society. Then strive to keep alive within these men, as well as ourselves, that spark of celestial fire called professional conscience, making one loyal to duty well done; loyal to those we serve; and, last but not least, loyal to our brother practitioners. Consecration to one's work and thoroughness in every operation is your duty, but, men, it is also your duty to identify yourself with your local, district, and State society; work for it, fight for it. The State laws governing the practice of dentistry in North Carolina rank with the best in the Union. This was brought about through enlightened and organized dentistry. We cannot keep truly enlightened by simply sending in our dues and staying at home. We cannot keep alive the ideal of those who have gone before and made this good fortune possible for us by sitting at home and letting our birthright drift; for unto us they flung the torch and it is ours to keep ablaze. And if I could here preach a sermon of courage

that would inspire your spirits to loftiest efforts, I know of no better text that I could take than the preamble of our Constitution. Our motto as therein expressed is to work together for the highest possible development of our profession and the attainment of each individual in his sphere of that excellence of character that will make him most valuable to his Creator and most serviceable to his fellow man. And let it here be said that no nobler objective could actuate the efforts of any body of men.

The dental profession, through the years this organization has been alive, has had a brood of evils to fight in order that it might survive unscathed and hold its place among the learned professions. Depression, jealousy, lack of appreciation, and ignorance in higher places have all snapped at our heels like vicious hounds and threatened to take us apart. Sinister forces have threatened to deflower us as a profession and leave us only a soulless cog in a soulless wheel, but we have come through the ordeal unharmed and unafraid. And, by reason of our conflicts, we are better equipped than ever to fight to a finish any enemy that should arise hereafter.

We know what the dental profession is, and what it means to health and happiness of humanity; we know the penalty paid by ignorance in the generations that have come and gone. We know that any profession, in order to reach an exalted position in the galaxy of humanity, must have a soul, and it must be free. In order to achieve its highest it must have ideals higher than salaries or monetary rewards. It must get close to the hearts of those it serves and it can never be more than a hireling until it becomes a part of its own clientele.

And speaking of a heart, I am led to say a word about petty jealousies within our own ranks, if there be such. Men, this is no time for jealousy and strife; there has never been and never will be a place for jealousy in the dental profession, and let me beg of you to be ever on the alert. The awful depression we have all experienced and the swiftly changing economic conditions, with its attenuating uncertainties for the future, furnish grounds for us to be tempted at least to disregard our neighbor practitioner, and thus lower the standards and prostitute our profession and self-respect by cutting fees or by subtle words or acts seeking to hog our brothers' clientele. In the name of humanity and the preservation of our own ideals and interests, let's stand against all such unprofessional and unethical behavior.

I do not know what the years ahead have in store for us; I do not know what the innovations of the future in the way of massed dentistry or public health insurance, or what not, will make bold to offer us.

But of one thing I feel that as long as our ideal is the highest possible development of our profession, and our ultimate purpose to make that development an engine for the greatest possible service to humanity, we cannot fail, no matter what imp of discord leaps into our path, or what monsters stalk among the shadows. For twenty centuries ago One who is mightier than any earthly obstacle said that the mortal who would be counted greatest around the council fires of the Deity would be the mortal who had served his fellows best.

Lastly, there is one grave danger in my mind of which I would warn you. This is a matter of which I hope I may speak without wounding the feelings of anyone, but be that as it may, I must nevertheless speak. There is one specter that, in my opinion, must be destroyed or else it will soon destroy us. I refer to our clandestine commerce with the commercial dental laboratories. Too many of us have turned over the work that we should have done ourselves to these institutions, with two inevitable results, which together threaten to wreck the dental profession, and to do it soon. We have enriched the laboratories and at the same time by lack of practice disqualified ourselves to do the highly technical and professional work we are supposed to do. In other words, through laziness, if you please, and carelessness we have been creating a Frankenstein that has now grown to such enormous proportions that it dictates to profession, openly takes the work from its hands, and will in a short time undoubtedly destroy if we do not bestir ourselves at once to stop it. It is amazing—it is appalling—that we, a set of highly trained men, schooled at great cost in a great profession, will turn our jobs over to a commercial institution and then take orders from those who have little or no concept of our profession and its purposes.

The commercial dental laboratory has its place and in its place is useful, but it is not licensed to practice dentistry, and let's make them know it. The dentist should never be a go-between between the dental laboratory and his patient. To do so would be acting untrue to those he serves. The best and only weapon, as I can see it, to stop the inroads being made into the profession by these commercial institutions is for us to begin at once to do the greater part of our laboratory work in our own offices; let's be the creators and designers of our work. We have the time and its up to us or suffer the inevitable consequences of having these institutions chiseling in upon our sacred rights.

So, brethren of a noble profession, I would shout a battle cry of courage to you this morning and call upon you afresh to carry on. Gird yourselves with a new faith in your profession and stick loyally to the ancient landmarks until our profession reaches the exalted position to which it is entitled, and its glory is owned and recognized to the ends of the earth. Our going is well established and we have nothing to fear as long as we are, in the words of Macbeth, "Bloody, bold, and resolute."

CHARLES I. MILLER, D.D.S.

FOURTH DISTRICT

PRESIDENT'S ADDRESS

Raleigh, N. C., October 12, 1934

The moral obligation imposed upon us by the act of practicing dentistry, I fear, is not fully appreciated by all dental practitioners. Those of us who have been practicing sufficiently long to get a practical idea of the quality of service rendered by the average dentist should be deeply impressed with the fact that many of us are missing many of the best

of our opportunities to really serve humanity. Some of us are often unfaithful to the trust placed in us by our patients. Why? Human frailty? Perhaps human laziness would be a more accurate answer. Our own inherent weakness of purpose explains it.

There is no failure except in no longer trying. Genius is only the power of making continuous effort. The line between failure and success is so fine that we scarcely know when we pass it; so fine that we are often on the line and do not know it. I speak of professional success, not material success, though if we succeed professionally, it naturally follows that we succeed in a material way. How many of us have thrown up our hands and quit at a time when a little more effort, a little more patience, would have achieved success. We all know that there are times, as we go about our daily task, that it requires an enormous energy to stay with our difficult, well-nigh impossible tasks and see them through to a successful end. And right here is where some of us fall down. We do not spend that extra energy to make a successful operation of what we are doing. A little more persistence, a little more effort, and what seemed hopeless failure may turn to glorious success.

Why do we succumb to this weakness of purpose, this inertia? Is it that we do not believe in the service we are handing out to our public? Pardon me, please, but I believe in the service I am handing out, and I believe in my ability to get results. I believe that honest service can be rendered to honest patients in an honest way. We err when we try to deceive our patients. Let us believe in working, not weeping; in boosting, not knocking; and in the pleasure of our job. We know that a man gets what he really goes after; that one deed done today is worth two deeds done tomorrow; and that no man is down and out until he has lost faith in himself. Let us believe in today, and the work we are doing; in tomorrow and the work we hope to do, and in the sure reward which the future holds. Let us not make the mistake of resting when we should be working. To rest is to rust. Real life is Love, Laughter, and Work! If you want to be a top-notcher, beware of the poker and the poolroom habit—otherwise, destiny awaits around the corner with a stuffed club. Better spend that energy preparing for the job tomorrow.

Man, like God, creates in his own image. This is particularly true of dentists. When you put in a restoration for your patient, you are like the painter who, when he paints a portrait paints two—one of himself and one of the sitter. If there is a sleazy thread in our character, we will weave it into the fabric we are making. When we get back to our offices, and look into the mouths of our patients, and observe our past handiwork, let us realize that we are looking at a little portion of ourselves.

Do you at times have trouble in preventing the dollar obscuring your view? Certainly! We are human. Being human, we fall victim to this same misconception that men do in all other lines of work, namely, dollars mean happiness and contentment and security. Rather, let us make an honest effort to realize that work skillfully done is the all-important thing, and that dollars come in proportion to the skill we use

in doing our work. Power flows to the man who knows how. Responsibilities gravitate to the person who can shoulder them.

Let us be loyal to the trust placed in us by our patients. Loyalty is a quality woven through the very fabric of one's being, and never a thing apart. Byron never wrote a muddy, slipshod line, nor could he be bribed or bought to do so. Michelangelo was ever and always loyal to his art, and this was why six Popes, under whom he worked, kissed his feet, and why we, too, kiss his feet, even yet. Success hinges on loyalty. Whether any one knows of your disloyalty is really of little moment, either one way or the other. The real point is, How does it affect yourself? Loyalty makes the thing you are striving for yours. Disloyalty removes it from you. Being disloyal to that trust placed in us makes us imagine someone has it in for us. And we are right, everybody and everything, including Fate and Destiny, have it in for us. The only man who goes unscathed is the one who is loyal to himself by being ever loyal to others.

The hospitals, jails, asylums, and sanatoriums are full of disloyal people—folks who have been disloyal to friends, society, schools, business, their work. Never say, "That will do," or "This is good enough." Nothing but your best is good enough. Stop when you are about to set that inlay, and look again. How about that gingival margin? When you dismiss your patient, after a scaling, have you done the job as thoroughly as you would have it done in your own mouth? Let that be your yardstick of quality. Loyalty to your patient and profession to the last! Stick! And if you quit, quit to tackle a harder job, and do it more skillfully than the last one, if possible! God is on the side of the loyal.

Are you loyal to your patient and to your profession when you are actually dishonest to your patient, to cover up the ignorance, or carelessness, of another dentist? If only a very weak solution of ethics reaches from us, to our patient, we are never required to deceive the patient regarding a condition or a necessary treatment, no matter what the patient thinks about the quality of the service he has been receiving. It is quite sufficient for all the requirements of loyalty and fair dealing, that we refrain from comment on our fellow practitioner; that we show the patient what is and what needs to be done, and let the patient form his own conclusions.

Do you ever have a patient say things right out loud which no dentist who cares for his reputation would wish to have said about him? If one tries to restrain them, they simply get madder and madder, and I have well-grounded suspicions that many a patient who is fairly restrained in a dental office may be very much more dangerous to the dentist's reputation in their social contacts with life. And that is as it should be. If we have the proper loyalty and pride in our art, we would not have it otherwise. Well, you say, ethics require a dentist to seek to justify the cause of the former practitioner. So it does, in cases of possible mistaken judgment, or where differences of professional opinion may be held, or when the difficulties of the case made it impossible for the dentist to render the kind of service that he desired and the

patient needed. Such cases form no part of my material for argument here. I am referring to the case where there was very much less than the average of care and knowledge and skill, which the law requires, or there was deliberate dishonesty. Let's take stock of ourselves. If we are doing these things, let's stop doing them. We'd better stop, not alone for the sake of our patients and our profession, but for the sake of our bank accounts as well.

IRBY HOYLE, D.D.S.

MAINTAINING A PROFESSIONAL VISION

The intellectual vision of every professional man is limited to the scope of his horizon, and the question is, Can we censure a man for not seeing what he cannot see? I sometimes wonder if we are not to blame, first, in our dental schools, then in our societies and associations, for sowing the seed, the harvest of which is reaped by quacks and unethical men.

First, the number of dental schools has increased out of proportion to the population, and this has necessitated some schools to resort to almost any method to secure students, and this method is undoubtedly mirrored in the professional and ethical character of the man thus secured. Music has gone jazz. Art has gone modernistic. Professions are going haywire. I believe in progress, new things and modernism, so long as we have a professional vision with an ethical guide; but modern business methods have no place in the higher sciences where human health and life are involved.

The men who have stood before our societies and talked of "Selling Dentistry" to our patients are men who are really interior decorators, and are selling gold crowns and root canal fillings and, incidentally, giving heart lesions and many other fatal diseases as a special Saturday premium to come later. The man who will solicit patients, directly or indirectly, will, without doubt, do work that should not be done, and will administer drugs that should not be administered.

The true dentist is not a business man. He is an artist and lives about twelve feet above the business world, and it is deplorable that conditions are such that he must ever think of his services in terms of coinage. When the grind of business appears, the symmetry of art is gone. A man must live, and most of us must live by our profession, but we do not have to live on the blood of a professional brother. The last few years have brought about drastic changes in every walk of life, and some men have not been fair enough to be willing to take their financial reductions, but have reduced their profession with their fees. The question of fees is an almost undiscussable problem, because "The servant is worthy of his hire," but the public is hard to understand why they can't all be hired at the same fee. Every dentist has a perfect right to charge as much as he likes, or as little as he thinks his services are worth, and no one would complaint; but when he reduces a fee below a minimum simply to keep a more competent man from getting a fair fee, he is cheapening the profession and reducing it to a

Trade. The better class of dentists do not mind any patient comparing their fees with a tradesman's fee; but it is unfair to compare the tradesman's fee with a good dentist's work. It is much easier to reduce fees than it is to get them back, and it is generally done at the expense of standards. Different men have different ways of exploiting, and I really have more respect for a dentist who would print a circular and tell the public he is cheap and should receive cheap fees than I have for the so-called ethical man who religiously works churches, lodges, Sunday schools, and dinner clubs to do the same thing.

It is impossible to put anything in a man. You can only develop that which is there. Doctors, like gentlemen, are born, not made. There are a great many things that have, in the past years, happened to have a tendency to make the little man smaller in his vision as to his profession, and when the little man gets small, the small man gets minute. Are we, our associations, societies, national and state boards of health, responsible for this condition? In a large measure we are. We have been over-zealous in our activities and charities, doing for others who did not deserve it nor appreciate it. Millions of dollars have been diverted from the practice of ethical dentists and doctors in national hospitalization, state hospitalization, county hospitalization, city hospitalization, welfare activities, free medical and dental clinics, and numerous other ventures that have taken this kind of patients from this kind of physician or dentist, to whom they would have gone and paid a fee that would have satisfied the man to whom they went. They no longer go, and it has forced the unethical practitioner to prey on the practice of the better men in order to make a living.

I believe our activities should be along educational lines only, and that in a short time our own State Board of Health will realize this and work along educational lines and discontinue any attempt at operating in our schools. I might say at this point that the education should not be directed nor limited to the children. The parents, and most in importance, the teachers, should be educated to proper dentistry and proper medicine and, most of all, they should be made to understand medical and dental ethics in order to know a quack from a professional man. Then, and only then, will they be able to recognize an ethical practitioner from a misrepresenting quack, and a prescription from a patent medicine.

I realize fully that to a fair degree we are our brother's keeper. But how long must we keep a brother, and what is the address of the brother who is supposed to keep us? In the last few years professional men have been harder hit than any other class of people, and when our government began relief activities in the shape of seed loans, crop loans, feed loans, it said to the salesmen, "We will lend the farmer the money to buy fertilizer, feed, and seed," but did not say it would be on one condition, that they must sell a $30.00 ton of guano for $15.00, or a $1.00 bushel of wheat for 50c, or a 50c bushel of cottonseed for 25c, but would lend the money to pay the regular price; but when we, as professional men, are asked to help with any government aid we are asked to do it free, or at less than half our accustomed fees.

These are some of the things that have probably reduced many of our men to a standard far below our own. If we maintain our professional respect we must bring about conditions that will make the public respect the profession. The public will never respect tradesmen in a profession, and the vital question now is, Who is responsible for this type of men being and staying in a science that deals with human life? Every dentist should saddle his part of charity in the scope of his own profession, then there would be no need for expensive organizations to give others' services and earnings to people who don't want it, and don't deserve it. When we, through any agency or organization, extract for a quarter, vaccinate for seven cents, and other treatments in proportion, we have lost our vision of a great profession and reduced our worth in the eyes of the very patient we think we are helping.

ARTHUR HYNES FLEMING, D.D.S.

[Read before the Fourth District Dental Society at Raleigh, N. C., December 5, 1933.]

FIFTH DISTRICT

PRESIDENT'S ADDRESS

Greenville, N. C., November 12, 1934

Members of the Fifth District, North Carolina Dental Society, visitors, and guests:

I desire first of all to express my sincere gratitude to this organization for the honor it has bestowed upon me in making me the presiding officer for the past year. I also wish to thank your very efficient secretary, Dr. Hand, for his untiring efforts in performing the numerous duties required of his office. I likewise appreciate the good counsel and many timely suggestions of others of our number. They have made this year's administration a pleasure.

The primary function of a district society is to develop the talent within the district, so that the best may be selected to appear before the State Society, and so on to the National organization. Gentlemen, one of the weakest points of the Fifth District is the indifference of its members to participate in the programs of the district meetings. I would suggest that every member take special cognizance of this fact, and when tendered an invitation to give a clinic or present a paper, do so in loyalty to his organization.

Dental science has marked up many advances along the road of progress during the last few years. It is today a profession which has in its trust the prevention and cure of disease of not only the mouth and jaws, but of the whole body. America is foremost in this field of science. Have we as individuals and as a district contributed enough to the general advance? We must not become parasitic. It behooves all of us to wake up and become particularly active. Nor can we longer let our interest die with the performance of duties strictly dental. Our obligations have increased with each year of our progress. We have aroused a great desire for our services; therefore, it is our duty to see

that these services are rendered. It is not the health and happiness of the few, but the well-being of the rich and poor alike that we must guard.

Our greatest obligation at present, then, is one of the most difficult problems we've had to face. It is to see that adequate dental attention reaches the indigent and those in the low-income bracket. If we do this, it will be the greatest advance in our history. Even though the Government or other agencies may want to bargain with us, we are not obliged to distribute this service gratuitously. Our moral obligation does not hinder us from demanding a fair income. Here I wish to emphasize the fact that it is up to organized dentistry to see that its members are adequately remunerated, and that the successful accomplishment of this program depends upon the coöperation and loyalty of each individual to the organization. The whole of dentistry must perfect a plan and organization to accomplish this end. Otherwise, we may be forced to accept a scheme unjust to us.

It has been called to my attention, and I fear that it is true, that over the district dental fees have been reduced to an absurd minimum. This reduction is not caused by the inability of the patients to pay, but to the competitive, fee-slicing commercialism of the practitioners themselves. Such tactics cannot be denominated as altruism or humanitarianism. These acts are entirely disloyal and unprofessional. To overcome this, there should be a stipulated minimum fee scale in every community. This will insure practitioners a better income, and establish a higher fee basis on which to build a probable future socialistic dental program. The adherence to this fee scale, of course, could not be enforced. Its success, therefore, would depend on that high sense of moral value which a few men in every organization sadly lack, and that few can disrupt the whole program. I believe that the greatest single need of the profession is a greater respect for the principles found in our Code of Ethics.

Someone has said that it takes more power to make a light than it does to make a noise. Anyone can make a noise, and noises will only lead the profession to destruction. It reminds me of mobs, noisy, unruly, and characterless. The things our profession has to face cannot be successfully approached in such a manner. We need much light to illuminate the many obstacles in our path. Can we not earnestly endeavor to produce the necessary power for this light?

Since this was written, a most brilliant light has been extinguished, that of Dr. James M. Parrott, Secretary of the State Board of Health. Though a physician, he felt kindly toward dental problems, and realized the importance of close interrelationship of the two professions for the advancement of public health service. His influence was great assistance to us in attaining the Department of Oral Hygiene as a unit of the State Board of Health, and representation on each county board. We cannot value the esteem of such men as he too highly. Let us faithfully uphold the principles of our profession as he so nobly upheld his.

H. K. Thompson, D.D.S., M.S.

Reminder: *A. D. A. Relief Fund—don't delay sending your contribution*

CHILDREN'S DENTISTRY

By A. L. Wooten

As a preliminary to the discussion of my subject, I ask that we go back in our minds to more youthful days when we were faced with the momentous task of deciding what we would do to sustain ourselves for the remainder of our years. I venture the assertion that most of us can now recall how we came to the conclusion that the dental profession was an honorable and dignified calling. We can add to that our conviction that dentistry was one of the surest ways of making a living. We may even recall how we dreamed of accumulating moderate riches by following a profession that demanded and—so far as we knew at that time—got high fees. So, after such consideration, and with the exercise of enormous youthful wisdom, we decided to become dentists.

Perhaps I judge too much by my own reactions to things, but I am prepared to defend myself in the assertion that few of us entered the profession for strictly humanitarian reasons. Our humanitarian reactions—if any—have been born of struggle and strife, either endured or observed.

It was some time after the beginning of our college career that we began to develop the professional point of view and to learn about ethics and professional responsibilities, etc. The responsibility of the dentist to his patient was properly stressed, though now it seems not always to be properly executed. It was drilled into the student that his position as a professional man gave him great powers of discretion. It was emphasized that often the life of the patients, and more often their health and comfort, came under the control of his skillful hands.

There came times when the weight of responsibility seemed unbearable, and there came times when it seemed that the sum total of all the facts that had been drilled into our heads was sufficient to prepare us for any emergency. There came times when responsibility was dreaded, and there were times when it was looked forward to with eagerness.

Few of us are endowed with special aptitude for the practice of dentistry. Most of us are, unfortunately, just average humans who would do as well, or perhaps better, at something else if we applied ourselves equally as diligently. We succeed only to the degree that we overcome the inaptitude that sometimes makes our progress slow and uncertain.

I am convinced that all of us are capable of doing all varieties of dental work with satisfaction. But as we advance in years and experience we develop a preference, and as a result of that, a special skill for certain types of work. And if we don't watch ourselves we are likely to neglect to some extent all types of operations except the ones we have grown to like best. For instance, there are many who avoid children's work simply because they don't like it. We do an injustice to ourselves and our patients when we neglect any class of work unless we refer that class of work to someone who will not neglect it.

It was quite by accident that I practiced children's dentistry for nearly eleven years. I did not go into it because I thought I was specially qualified for the task. I needed a monthly salary and Dr.

Johnson needed one more man on his staff. It took me several years to fully realize that children's work appealed to me more than any other class of dental service. It took years, also, for me to begin to realize the scope and importance of this branch of dentistry. I have no doubt that I have much to learn yet in that respect.

This much I can say, all that I do know about the practice of dentistry for children seems simple. Otherwise, I perhaps wouldn't know it.

The one fundamental upon which the successful practice of children's dentistry is based is the full and intelligent coöperation of the parents. I hasten to assert that full and intelligent coöperation is hard to get. In fact, it can be said to barely exist.

Dividing children in two general classes, we find a wide variation in the responsibility of the dentist to these two classes. If the parents place the child in the care of the dentist and follow his instructions carefully, those parents have the right to expect that child to pass through childhood with the minimum dental disorders, or none at all. The dentist in this case may expect almost complete success if he follows his own best judgment, and observes the rules and practices of the authorities on the subject. There is no branch of dentistry in which there is so little controversy concerning methods of practice. In fact, there is such unanimity of opinion that it is difficult to get up a first-class argument.

The other class of children, that is, those whose parents never have anything done except when trouble arises, and often not even then, places no responsibility on the dentist other than that of taking care of the emergencies with which he is presented from time to time. If these children develop faces like apes it is not the fault of the dentist, except as that dentist, or his profession, has failed to advise the parents properly and at the proper time. If their mouths smell to high heaven with their accumulation of filth, the dentist cannot be blamed unless he has had the opportunity to treat these cases as early and as late and as completely as he wishes.

I have said that all I know about the practice of dentistry for children is simple. It is not difficult to understand why a child should have dental attention of some sort as soon as he has teeth. It is elemental that at an early date the dentist should have an opportunity to inspect them. And if he takes the inspection seriously, as he should, the treatment he may find necessary will be simple, and the advice that he gives the parents concerning the time for the next visit will be simple and easily understood and impressive. There is such variation in the quality of teeth that the advice for different children will vary greatly.

If we are going to give the child dental health and comfort, which should be our aim, we must, contrary to the practice of many general practitioners, find and fill or treat all cavities in their incipiency—as well as observe the growth of the whole face to detect maldevelopment of any kind.

All cavities, except those in teeth that have only a short time to serve, should be filled as soon as they can be discovered. The filling material

should be that that is most likely to be permanent. Exception may be made in the case of babies that are too small to manage. In these cases silver nitrate should be used to hold the decay in check until a filling can be placed.

It is seldom practical to fill deciduous anterior teeth. For these cavities silver nitrate, although unsightly, is an excellent substitute, and will, if properly used, hold the decay in check. When cavities have been treated with silver nitrate and no filling placed it is necessary to check occasionally to see if the surface remains black. If a sharp-pointed instrument will not remove the black deposit, your treatment remains satisfactory. However, there is no harm in repeating as an added precaution. It is to be remembered that in treating a tooth with silver nitrate when no filling is to be placed all soft decay should be removed and the cavity left in as nearly a self-cleansing shape as possible.

Because of the danger of unnecessarily exposing the pulp, it is sometimes advisable in deep cavities to leave a very little soft decay when fillings are to be placed following the use of silver nitrate. However, if the silver nitrate does not penetrate to the depth of the decay, success will not attend your effort.

The best silver nitrate I know for such treatment is Comdit's Ammoniacal. Or if you know how, you can prepare a similar product at much less cost. (Page 2051, November, 1934, Journal A. D. A.) For the best results in these treatments, the cavity should be thoroughly dried, using alcohol to aid in dehydration. Cotton rolls should be used to maintain a dry field. It is often helpful to have the child hold the cotton rolls on the lingual side. Care should be taken to protect the soft tissues.

When filling deep cavities that require the use of silver nitrate they should be lined with a sedative, germicidal cement. This applies to both deciduous and permanent teeth. The best preparation I know for this purpose is Carbol-Eugenol and silver nitrate powder. Silver nitrate crystals don't work so well. The mixture should be twenty-five to forty per cent silver nitrate, and it should be mixed thick, almost to the point of stiffness. If you can anticipate the need of it, mix fifteen to thirty minutes before you will need it, and leave it on the slab. Place it in a dry cavity and let the saliva to it immediately. You can place the filling at once or wait a day, or a month. If you proceed at once it will be necessary to be careful in condensing the filling. Pack mostly toward the lateral walls until the cavity is overfilled. Then the margins may be condensed without forcing the more or less soft base up the cavity walls and ruining the filling.

In the report of the Council on Dental Therapeutics in the September Journal, Carbol-Eugenol is not accepted. However, no actual fault is found with the formula. It is explained that the formula is similar to preparations in long use and can be prepared at much less cost.

You may have your choice of filling materials so long as you don't depend too much on cement and gutta percha. There are some cavities

that cannot possibly be prepared for other filling materials, and in these cases cement may be considered better than silver nitrate alone.

Where it is possible, silver amalgam, copper amalgam, or gold should be used. Of these three, silver amalgam can be used in perhaps 90 per cent of the cases. Due to the cost of inlay work, gold is, of course, largely eliminated as a filling material for deciduous teeth. However, there are many instances where it would be the most satisfactory material to use. Copper amalgam stands in great favor with many operators, and while I am convinced of its value, especially where the pulp is endangered, I have not used a great deal of it.

In the case of very bad cavities you either have or you have not an exposure. The simple technique briefly described above will take care of practically all cases where there is no exposure. If there is an exposure in a deciduous tooth I know of nothing that will take care of it with any degree of certainty. It is true that some operators do remove the pulp and fill the canals, or perhaps just the pulp chamber. I am not convinced that any great per cent of these cases are successful, and I do not often attempt them. I do attempt with fair success the capping of pulps of permanent teeth when they are exposed in sound dentin. Extraction seems best when the pulp is exposed in decay, except in anterior teeth that have sufficient root development to permit successful root canal work.

With the above exception, I urgently recommend the extraction of all teeth in the mouths of children that have the pulps exposed by decay, or have gone far beyond that point. Bear in mind that if we are dealing with parents who take care of emergencies only, we have taken care of the emergency with the extraction of the tooth. Not only have we taken care of the emergency, but we have instituted a safeguard against the long-drawn-out chronic infection that is so likely to follow any other course of procedure. The disadvantages of maldevelopment following premature extraction are not to be compared with the risk we encounter by leaving abscessed, or near abscessed, teeth as space retainers.

On the other hand, if we are dealing with parents who give us 100 per cent coöperation, we have few exposures. In these few cases extraction and the application of space retainers seems to be the solution. It is true that most of us have never placed a space retainer. For this failure we can hold ourselves largely responsible. I feel justified in saying that in the case of premature loss of posterior deciduous teeth in the mouths of children whose parents coöperate, we fall far short of our duty if we fail to maintain the proper spaces by suitable appliances.

I will pass the matter of child management up with a few brief sentences. The first consideration is the proper psychologic approach, and this is of major importance. However, do not suppose that any amount of psychology can overcome entirely all the damage done by well-meaning parents and relatives who convey unwittingly their own fears to the child before he ever reaches the office.

Deal gently with the child without ladling out too much honey and sugar. Be honest and truthful and, if necessary, firm. It is a wonderful thing to have a child love you, and that should be our aim. At the

same time it is necessary that the child respect you, and recognize your authority, if you would successfully cause him to endure against his will the discomforts of dental operations.

In the management of the rebellious child you are in greater need of the parent's coöperation than at any other time. They should coöperate by leaving the office and showing that they have confidence in your ability to handle the situation properly. I spoke of being firm. But firmness is ineffective if the parents are standing by saying the wrong things, and making impossible promises, as they almost invariably do. The child can listen to only one person at a time. And only one person should be left to reason with him or give him orders, and that one person should enforce the orders he gives. He should naturally be careful not to give unreasonable orders.

I have recently read an article by a man who says he wins the confidence of his child patients by assuring them that he will not hurt. I seriously doubt that a skeptical child's confidence can be won that way. And I doubt, also, that such promises can always be kept. I never promise a child that I won't hurt when I go to extract or fill a tooth. In fact, I make few definite promises, and avoid the subject of pain as much as possible.

Both in the management of the child and in the normal control of pain local anesthesia takes on considerable importance. Conduction anesthesia is my choice for the extraction of all lower teeth, except loose ones. I have used it for children as young as four years. While I have seldom found it necessary for cavity preparation, I have no objection to its use for that purpose, provided that necessary precaution is taken for the protection of the pulp. There is always the possibility of exposing a pulp unknowingly and filling a tooth that will come back next day (if not that night) in great pain. In which case extraction may be necessary.

A paper on children's dentistry without a few paragraphs on diet is perhaps very incomplete. But I know nothing about diet. I have read, as you have, many contradictory essays on the subject. There have been recommended innumerable combinations of all the foods from uncooked vegetables to fancy calcium and phosphorous concentrates. We are confronted by many angles of this problem from a widening front as more and more authors take up the argument. In spite of all the progress made in diet experimentation, it is difficult to disregard the observation that children of poor families in the remotest rural communities very frequently have better teeth than their city cousins, who supposedly have better advantages. After the examination of many thousands of children in all stages of poverty and wealth, I have come to the conclusion that children living in the country and poor children living anywhere have the best chance of developing teeth of natural good quality. The simplicity of the food they get and the absence of the in-between-meal candy and other appetite-destroying habits is undoubtedly partially responsible.

There is a constant stream of distressed mothers about ready to give up the struggle when they see the child they have fed all the recom-

mended foods and preparations losing his teeth from decay. These failures do not condemn the attempt to regulate the child's diet, but rather should spur us on to a greater effort to apply what little we do know more effectively.

It has been my intention in this discussion to take up briefly some of the every-day problems that confront the dentist in his child practice, and to explain solutions that have proven successful in my hands. I am not so much interested in methods as I am in results. It doesn't matter a great deal how you give the child dental health so long as you do it. There is no satisfaction that I know of in the practice of dentistry comparable to that of the consciousness that you have been instrumental in the building of a sound foundation for permanent natural dentition, and that through your aid permanent beauty, health, and happiness have been enhanced.

[Delivered before the Fifth District Society at Greenville, N. C., November 12, 1934.]

TO

DR. J. A. SINCLAIR

Who has ventured to travel unused paths
and has carved for himself a niche
in the corridor of dentistry

THE BULLETIN

....of....

THE NORTH CAROLINA DENTAL SOCIETY

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BLOWING ROCK

Blowing Rock, the most unique and beautiful resort in the Blue Ridge Mountains, gets its poetic name from the colossal rock that leans out far over the deep gorge of John's River. It lies in the edge of Watauga County, midway between the Shenandoah National Park and the Great Smoky Mountains Park, and is the highest incorporated town east of the Rocky Mountains. The resort is 4,300 feet above sea level, and nestles at the foot of Grandfather, the second highest peak in the Southern Appalachians. The giant peak gets its name from the fact that its surface, eight miles in length, resembles the face of a sleeping giant, and it is said to be the oldest geological formation in the world. The Grandfather is 5,997 feet above sea level and dominates the landscape for fifty miles around.

The average temperature of Blowing Rock is 76 degrees. The air is always cool and invigorating. There are no mosquitoes and very few insects of any kind because of the altitude, and the climate is the most delightful imaginable. The town is a resort, pure and simple. There are no factories, no unpleasant sounds, and no disturbing factors. It is a natural playground.

The approaches to Blowing Rock are excellent hard-surfaced State Highways. These roads traverse the most beautiful scenery in Eastern America, and the famous "Yonahlossee" ("Trail of the Black Bear"), across the Grandfather, is known as the most beautiful road in the Appalachians. Waterfalls, sheer rock cliffs, breath-taking vistas of distant peaks overhanging lovely valleys, and miles

The Rock, Blowing Rock

of virgin forest in which the lordly spruce predominates, are some of the features of these roads.

The flora of this section is the most beautiful and varied in the world. In fact, this beautiful country was first introduced to the world by botanists. In 1794 André Michaux, famous naturalist of the French Academy, came through the Grandfather country collecting beautiful specimens of shrubs and flowers to plant in the palace gardens at Versailles. He said then that he could find

more beautiful varieties of blooming plants in an hour's walk on the Grandfather than in a trip from the East to the West of Europe, and described the flora of this great mountain as the most beautiful in the world. Asa Gray, the great University of Pennsylvania botanist, collected many specimens here, and said that this section was the best collection ground in the United States.

The reasons for this wealth of beautiful flowering plants are: The depth and richness of the soil, caused by centuries of erosion; the moisture, and fine climate. The coloring of the flowers in the Blowing Rock country is also particularly rich and lovely. The depth of coloring in the crimson rhododendron, the flame azalea, the punktatum, laurel, pink azalea, and other shrubs cannot be described. The rhododendron thickets and laurel "wooly heads" are gorgeous. The ground flowers are equally beautiful and carpet the earth from early spring to October with masses of beauty.

The homes and estates around the resort are beautifully landscaped and planted. Garden flowers, as well as wild flowers, attain great size and coloring there, and the gardens are the pride of the place. These estates belong to owners who allow the tourist to share the beauty of their gardens, lakes, flowers, and views. Miles of well-kept roadways, bordered by giant trees, purple, crimson, and pink rhododendron, masses of laurel or kalmia, azalea that ranges from a pale pink to deep flame color, trillium, lilies, galax, rattle root, and thousands of other rare and beautiful wild flowers are in and around Blowing Rock. And, as you ride along these roads, a sudden opening in the timber will reveal a vista of thousands of distant peaks piled in untold majesty against a deep blue sky.

Some of the best known of the nearby peaks are: Hawksbill, Table Rock, Green Hill, The Beech Mountain, Rich Mountain, Flat Top, and hundreds of others as beautiful.

Blowing Rock has been a famed and exclusive resort for many years. Its beauty, the quality of its hotels and eating houses have attracted many people, and there are hundreds of cottagers who return year after year. It has been a famed resort since before the Civil War, and has kept unsullied the beauty and charm that attracted the planters from the Deep South to seek its lovely vistas and cool heights.

Of interest to the Dental Profession is the opinion of the Supreme Court of the United States which was delivered by Mr. Chief Justice Hughes in Washington on April 1, 1935, and is reprinted in this BULLETIN on page 15. Please read it.

It is now an established custom to dedicate each issue of the BULLETIN to some living member whose life and work has enriched his community, and profession. Your editor would be glad to have you recommend someone to whom this distinction might be awarded. Below is a list to whom the BULLETIN has already been dedicated:

April,	1928—C. L. ALEXANDER
October,	1928—J. N. JOHNSON
March,	1929—J. S. SPURGEON
May,	1929—G. W. WHITSETT
December,	1929—J. M. FLEMING
March,	1930—J. S. BETTS
April,	1930—F. L. HUNT
November,	1930—E. J. TUCKER
April,	1931—R. H. JONES
October,	1931—G. M. COOPER
January,	1932—CONRAD WATKINS
April,	1932—J. H. WHITE
October,	1932—J. S. BETTS
January,	1933—J. B. LITTLE
June,	1933—J. E. WYCHE
October,	1933—D. E. MCCONNELL
January,	1934—W. J. CONRAD
June,	1934—W. T. SMITH
October,	1934—E. B. HOWLE
May,	1935—J. A. SINCLAIR

NEW ORLEANS

AMERICA'S MOST INTERESTING CITY HAS A SCIENTIFIC TREAT IN STORE FOR YOU

— • —

Attend the American Dental Association Convention, November 4-8, 1935, and enjoy real Southern Hospitality

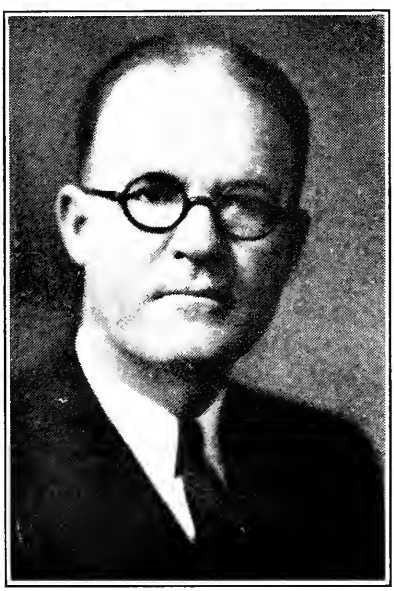
"There will be a meeting of the Alumni Association of the Atlanta Southern Dental College in Atlanta, at the College, on May 28th and 29th.

"An attractive program has been arranged, and every Alumnus is cordially invited to attend this meeting."

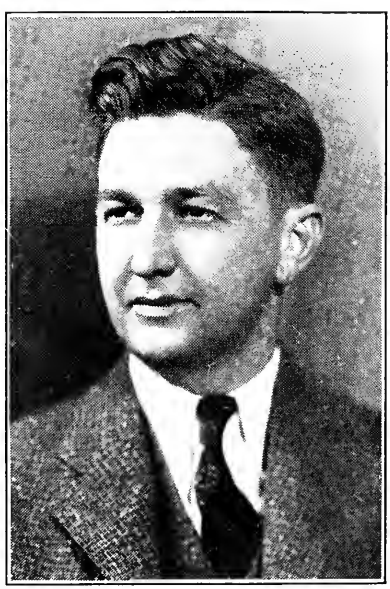
F. O. Alford, Chairman,
Program Committee.

Annual meeting of the Virginia State Dental Association, July 1, 2, 3, 1935, at The Homestead, Hot Springs, Virginia. Members of the North Carolina Dental Society are invited to attend. An excellent program has been provided.

DR. L. M. EDWARDS,
President of the North Carolina Dental Society



DR. Z. L. EDWARDS,
President-elect of the North Carolina Dental Society



DR. D. L. PRIDGEN,
Secretary-Treasurer of the North Carolina Dental Society

PRESIDENT'S MESSAGE

You have now received the last BULLETIN to be published prior to the sixty-first annual meeting of the North Carolina Dental Society to be held at Blowing Rock, June 17, 18, and 19. This issue carries the program for the meeting and, after looking it over, I feel sure you will appreciate the time, effort, and work of the various committees in formulating this splendid program. The scientific section is most appealing, the sport and social alluring, and the place of meeting most enchanting.

This, of course, is a bid for each one of you to go to Blowing Rock and spend the three full days. The committees, along with your hard-working Secretary, Dr. Pridgen, have been tireless in their efforts to give you this meeting, and you will be the loser if you fail to attend. And your friends will be losers if they miss the fellowship of your company.

Much constructive work has been done during the past year by some of the standing committees, notably, the Legislative Committee. The re-writing and ratification by the General Assembly of the new Dental Law is of outstanding importance. The decision of the Supreme Court of the United States upholding the Oregon State Board of Dental Examiners against advertising is a great victory for dentistry. Progress and advancement to the benefit and uplifting of our profession is being recorded each year, and North Carolina is in the forefront of this progression.

We have an organization of which the members can well be proud. However, we need and should have more members. Dr. F. M. Casto, President of the American Dental Association, is asking the support and coöperation of each state in increasing the membership of the A. D. A. to 45,000 in 1935 and from a census of practicing dentists has pro-rated the necessary new members each state must secure in order to attain this goal. Basing this on 70 per cent membership of the dentists practicing in each state, North Carolina needs 44 new members. There are six states over their quota, others considerably below. Our needed number is comparatively small.

Quoting from Dr. Casto's communication: "May I call your attention to the urgent necessity of increasing our membership. It will be one of the most important factors in coping with our present problems. Potency and strength under existing conditions lie in numbers. In effective negotiations with outside agencies, we must represent a large per cent of the profession.

"I have set the goal at 45,000 members for 1935, and we can reach this goal with the wholehearted support and coöperation of all concerned. I need not tell you that there never has been a time in the history of dentistry when organization was so important, unity of action so imperative, and honesty of purpose so necessary."

May I ask the members of the North Carolina Dental Society to make an effort to contact some ethical non-member with a view of securing his or her membership. It is not unreasonable to assume that 44 additional members can be brought into our society and thus North Carolina can be counted in as one of the states responding to the appeal of our parent organization. And by so doing we will have benefited greatly our State society. The nearer we attain a 100 per cent membership of the ethical dentists, the better we will function as an organized body. This will mean still better coöperation, uplifting of our profession, and better dental conditions from every standpoint. Let each member keep this in mind and make a real effort to do his part in helping secure a new member.

L. M. Edwards, D.D.S.

"ON TO THE BLOWING ROCK MEETING"

"On to the Blowing Rock Meeting" should be the slogan of every one at this time. The fellows in the West are doing everything humanly possible to provide for our entertainment and happiness while there.

During the past month I have attended a number of group meetings here in the Fifth District and am glad to say that everywhere I have been I have found the enthusiasm for the meeting that indicates a large attendance from the East.

As the time approaches for my installation as your president during the next year it is but natural that I should begin to think seriously of our organization and some of its many problems to be considered. I am duly cognizant of the responsibilities incident to the honor, and that the success or failure of each administration depends largely upon the leadership furnished by its officers. On the other hand, no parent organization can approach the ideal in its accomplishments without the coöperation and coördinated efforts of the officers and members of the component societies. Each man is a cog in the wheel of organization, and if some officer or

committee chairman fails to function in his position, the organization will be weakened and our efforts retarded to that extent.

I have entertained for some time a pet idea that there should be a closer contact between the officers of the State organization and the officers of the district societies. In order to realize this ambition it is my desire to have an Officers' Conference in the form of a Dutch breakfast some time during our State Convention.

Each district officer will be invited and expected to attend this breakfast.

Mayview Manor, Blowing Rock, N. C.
Convention Headquarters

At this time each man will be given a few minutes time in which to state his problems and offer suggestions. As a result of such an opportunity to develop a better acquaintance, and through the exchange of ideas, I feel confident that each of us will be inspired to realize fully our individual capacity for the faithful performance of our official duties, and that a desire for mutual helpfulness and a more sympathetic understanding will be promoted.

Z. L. Edwards,
President-elect, N. C. Dental Society.

SUPREME COURT OF THE UNITED STATES.

No. 538.—October Term, 1934.

Harry Semler, Appellant, *vs.* Oregon State Board of Dental Examiners, L. A. Rosenthal, Leonard R. Andrews, et al., etc.	Appeal from the Supreme Court of the State of Oregon.

[April 1, 1935.]

Mr. Chief Justice Hughes delivered the opinion of the Court.

This case presents the question of the validity of a statute of the State of Oregon, enacted in 1933, relating to the conduct of dentists. Oregon Laws, 1933, Chapter 166. Previous legislation had provided for the revocation of licenses for unprofessional conduct, which, as then defined, included advertising of an untruthful and misleading nature. The Act of 1933 amended the definition so as to provide the following additional grounds for revocation:

"advertising professional superiority or the performance of professional services in a superior manner; advertising prices for professional service; advertising by means of large display, glaring light signs, or containing as a part thereof the representation of a tooth, teeth, bridge work or any portion of the human head; employing or making use of advertising solicitors or free publicity press agents; or advertising any free dental work, or free examination; or advertising to guarantee any dental service, or to perform any dental operation painlessly."

Plaintiff, a dentist practicing in Portland, Oregon, brought this suit in the state court against the members of the State Board of Dental Examiners to enjoin the enforcement of the statute, alleging that it was repugnant to the due process and equal protection clauses of the Fourteenth Amendment, and impaired the obligation of contracts in violation of Section 10, Article I, of the Constitution of the United States. The circuit court, overruling this contention, sustained a demurrer to the complaint and, upon the refusal of plaintiff to plead further, the suit was dismissed. On appeal, the Supreme Court of the State took the same view of the federal question and affirmed the judgment. 34 Pac. (2) 311. The case comes here on appeal.

Plaintiff alleged in his complaint that he was licensed in 1918; that he had continuously advertised his practice in newspapers and periodicals, and by means of signs of the sort described in the amended statute, and that he had employed advertising solicitors; that in his advertisements he had represented that he had a high degree of efficiency and was able to perform his professional services in a superior manner; that he had stated the prices he would charge, had offered examinations of prospective patients without charge, and had also represented that he guaranteed all his dental work and that his dental operations were performed painlessly. He further alleged that the statements in his advertisements were truthful and were made in good faith; that by these methods he had developed a large and lucrative practice; that through long training and experience he had acquired ability superior to that of the great majority of practicing dentists; that he had been able to standardize office operations, to purchase supplies in large quantities and at relatively low prices, and thus to establish a uniform schedule of charges for the majority of operations; also that he had made contracts for display signs and for advertisements in newspapers, and had entered into other engagements, of which he would be unable to take advantage if the legislation in question were sustained, and, in that event, his business would be destroyed or materially impaired.

Plaintiff is not entitled to complain of interference with the contracts he describes, if the regulation of his conduct as a dentist is not an unreasonable exercise of the protective power of the State. His contracts were necessarily subject to that authority. *Rast v. Van Deman & Lewis*, 240 U. S. 342, 363; *Union Dry Goods Co. v. Georgia Public Service Commission*, 248 U. S. 372, 375, 376; *Sproles v. Binford*, 286 U. S. 374, 391; *Stephenson v. Binford*, 287 U. S. 251, 276. Nor has plaintiff any ground for objection because the particular regulation is limited to dentists and is not extended to other professional classes. The State was not bound to deal alike with all these classes, or to strike at all evils at the same time or in the same way. It could deal with the different professions according to the needs of the public in relation to each. We find no basis for the charge of an unconstitutional discrimination. *Watson v. Maryland*, 218 U. S. 173, 179; *Miller v. Wilson*, 236 U. S. 373, 384; *Missouri ex rel. Hurwitz v. North*, 271 U. S. 40, 43; *Dr. Bloom, Dentist, Inc. v. Cruise*, 288 U. S. 588.

The question is whether the challenged restrictions amount to an arbitrary interference with liberty and property and thus vio-

late the requirement of due process of law. That the State may regulate the practice of dentistry, prescribing the qualifications that are reasonably necessary, and to that end may require licenses and establish supervision by an administrative board, is not open to dispute. *Douglas v. Noble,* 261 U. S. 165; *Graves v. Minnesota,* 272 U. S. 425, 427. The State may thus afford protection against ignorance, incapacity and imposition. *Dent v. West Virginia,* 129 U. S. 114, 122; *Graves v. Minnesota, supra.* We have held that the State may deny to corporations the right to practice, insisting upon the personal obligations of individuals (*Miller v. State Board of Dental Examiners,* 90 Colo. 193, 287 U. S. 563), and that it may prohibit advertising that tends to mislead the public in this respect. *Dr. Bloom, Dentist, Inc. v. Cruise,* 259 N. Y. 358, 363; 288 U. S. 588.

Recognizing state power as to such matters, appellant insists that the statute in question goes too far because it prohibits advertising of the described character, although it may be truthful. He contends that the superiority he advertises exists in fact, that by his methods he is able to offer low prices and to render a beneficial public service contributing to the comfort and happiness of a large number of persons.

The state court defined the policy of the statute. The court said that while, in itself, there was nothing harmful in merely advertising prices for dental work or in displaying glaring signs illustrating teeth and bridge work, it could not be doubted that practitioners who were not willing to abide by the ethics of their profession often resorted to such advertising methods "to lure the credulous and ignorant members of the public to their offices for the purpose of fleecing them." The legislature was aiming at "bait advertising." "Inducing patronage," said the court, "by representations of 'painless dentistry,' 'professional superiority,' 'free examinations,' and 'guaranteed' dental work" was, as a general rule, "the practice of the charlatan and the quack to entice the public."

We do not doubt the authority of the State to estimate the baleful effects of such methods and to put a stop to them. The legislature was not dealing with traders in commodities, but with the vital interest of public health, and with a profession treating bodily ills and demanding different standards of conduct from those which are traditional in the competition of the market place. The community is concerned with the maintenance of professional standards which will insure not only competency in individual practitioners, but protection against those who would prey upon a public pecu-

liarly susceptible to imposition through alluring promises of physical relief. And the community is concerned in providing safeguards not only against deception, but against practices which would tend to demoralize the profession by forcing its members into an unseemly rivalry which would enlarge the opportunities of the least scrupulous. What is generally called the "ethics" of the profession is but the consensus of expert opinion as to the necessity of such standards.

It is no answer to say, as regards appellant's claim of right to advertise his "professional superiority" or his "performance of professional services in a superior manner," that he is telling the truth. In framing its policy the legislature was not bound to provide for determinations of the relative proficiency of particular practitioners. The legislature was entitled to consider the general effects of the practices which it described, and if these effects were injurious in facilitating unwarranted and misleading claims, to counteract them by a general rule even though in particular instances there might be no actual deception or misstatement. *Booth v. Illinois*, 184 U. S. 425, 429; *Purity Extract Company v. Lynch*, 226 U. S. 192, 201; *Hebe Company v. Shaw*, 248 U. S. 207, 303; *Pierce Oil Corporation v. Hope*, 248 U. S. 498, 500; *Euclid v. Ambler Company*, 272 U. S. 365, 388, 389.

The judgment is affirmed.

Judgment affirmed.

A true copy.

Test:

Clerk, Supreme Court, U. S.

THE LANE COUNTY, OREGON, PLAN

In Lane County, Oregon, has been developed the "Lane County Plan of Dental Health Education."

This plan has received the commendation of the Sociological Department of the State University, who would like to put the program on throughout the State, but are unable to do so at the present time because of the shortage of funds.

From a dental health bulletin coming from Eugene and the Lane County Public Schools to the parents is quoted the following:

"Health instruction is one of the chief duties of the school system. The plan of dental inspection and dental health education carried out last year is going to be followed again. This plan is primarily educational in character.

"We feel that a large part of the success of this work depends upon understanding by the home, and hope that this brief bulletin will help you to visualize just how the plan is organized, its purpose and value.

"The plan is based upon three well recognized fundamentals: *Education, Prevention,* and *Correction.* It will be seen that these three include the School, the Home, and the Dentist. With these agencies coöperating to the fullest extent, we believe that healthy mouths and happy growing children are a certainty. Health is largely a matter of habits, and those are formed through suggestion and continuous repetition. The home is a party to every aid in the correction of dental disorders.

"Three simple facts are emphasized in this program: 1. Good food. 2. Visit the dentist. 3. Home care of the teeth."

An inquiry addressed to Dr. W. E. Moxley, 501 Miner Building, Eugene, Oregon, will bring to those interested further details.

[Written for the American Association of Dental Editors.]

NEW YORK CITY HEALTH COMMISSIONER'S VIEWS ON PRESENT DENTAL PROBLEMS

The significance of dentistry as a public health factor was pointed out at the Centennial Meeting recently held in New York by Dr. John L. Rice, Health Commissioner of New York City, and Dr. Harlan H. Horner, Assistant Commissioner of Higher Education of the State of New York. Commissioner Rice credited the change in the public attitude towards dentistry to the general recognition of the role played by focal infection and the research that is being conducted into the cause of dental decay. "It is these factors," according to Commissioner Rice, "that have aligned the dentist with the public health officer in a common endeavor to improve the health of the public." The dentistry of tomorrow, as viewed by Commissioner Rice, will be for the masses rather than for the few. Furthermore, it will be largely preventive and will include education, diet, nutrition, home care, and the necessity for systematic service by the dentist.

Dr. Horner threw down the gauntlet before American Dentistry: "Dentistry can claim its rightful place in the social order when it develops its teaching and research on a parallel with medicine. . . . The reconstruction of the dental educational program in the light of scientific progress and of social demands is a responsibility now

resting squarely upon the shoulders of American dental educators." Apropos of the economic unrest, confronting dentistry as well as all of the medical arts, Dr. Horner had the following to say: "Our boasted twentieth century civilization needs to pause in its self-applause until it finds a way to bring the benefits of the dental art and science we now possess to the relief of the 79 per cent of our 125,000,000 people who regularly receive no dental care in any given year. That is an economic problem first and a professional problem second. We ought to have ingenuity enough to accomplish this noble end without destroying the relationship which exists between individual dentist and individual patient, and with-

A Blowing Rock Summer Home

out asking dentists to bear burdens which society in general should assume. The problem in all its economic and professional aspects is in many ways the most far-reaching and serious issue before the American people today. The challenge of it gives zest and promise to the dentistry of the coming years." This quotation embodies vastly more than has ever been expressed in the countless volumes written by our dental economists.

In conclusion, it is our belief that the first centennial celebration of American dentistry has helped to emphasize the growing change in the underlying philosophy of the profession. This way leads to prevention rather than repair; health preservation rather than replacement by artificial, mechanical substitutes and, above all, dentistry for all rather than for a favored few.

[Written for the American Association of Dental Editors.]

THE A. D. A. MEMBERSHIP PLAN

The Bureau of Public Relations

By Lon W. Morrey

The past decade has witnessed a tremendous increase in the amount of dental health information broadcast, printed, and otherwise disseminated by commercial organizations. Unfortunately, however, much of this information is worse than useless because of its misleading, biased, and unscientific nature.

If we as dentists would warrant the title "doctor" we must be more than healers of dental disease; we must be that which the title "doctor" implies—teachers. We must teach the public the necessity of dental care and the value of preventing dental disease. Realizing the importance of lay education in the prevention and control of dental disease, the American Dental Association in 1922 established, in the central office, a Bureau of Dental Health Education. This name has since been changed to the Bureau of Public Relations.

The Bureau of Public Relations does exactly as its name implies. It establishes public relations with other health and social agencies which are, or might be, interested in our problem. The Bureau collects and clears dental health ideas and materials. Through this office, all members of the Association may quickly and easily exchange their ideas on dental health subjects. For instance, you have perfected a dental health plan which has proved beneficial to you and your community. You forward that plan to the Bureau of Public Relations, where it is immediately made available to every member of the Association. In like manner, you have access to the plans and ideas developed by others.

Besides acting as a clearing house for ideas, the Bureau is constantly developing new lay educational material. Lectures, radio talks, newspaper articles, stereopticon slides, motion picture films, models, posters, leaflets, and schoolroom material, all of which is authentic and interesting, may be obtained from this office. Most of the newer educational material bears the official approval of the American Dental Association and the United States Public Health Service. All of this material is available at small cost to the members of our profession and others interested in dental education.

Lay education is of paramount importance in the prevention of dental disease. New educational ideas are in constant demand.

No one individual, no one bureau has a corner on ideas. The more each member contributes to the Bureau of Public Relations and the more each member uses the material offered by the Bureau, the better for both the public and the profession.

A Blowing Rock View

After all, it is not the ideas which we have in our own heads that count; it is the ideas which we can introduce into the heads of others that bring results. The Bureau of Public Relations is your servant. The more use you make of the Bureau, the better you, your patients, and the public will be served.

[Written for the American Association of Dental Editors.]

RULES AGAINST MEDICAL SERVICE BY CORPORATION

JUDGE'S DECISION HERE MAY HAVE EFFECT ON VARIOUS CLINICS

Chicago, Ill.—Chief Justice Michael L. McKinley of the Superior Court rules that a corporation is not permitted under Illinois statutes to practice medicine. The decision, if upheld by the Supreme Court, is expected to have a far-reaching effect, and may result in the closing of several organizations now devoted to the practice of medicine.

The case was brought by Attorney-General Otto Kerner on a *quo warranto* proceeding questioning the right of the United Medical Service, Inc., 23 East Jackson Boulevard, to practice medicine. The service was organized two years ago and has been subjected to criticism by members of the Illinois and Chicago Medical societies.

Judge McKinley pointed out that the Supreme Court has held that a corporation cannot practice law, and held that ruling as a precedent for his own decision that a corporation cannot practice medicine. What effect the ruling will have upon hospitals, clinics, and similar institutions was not immediately determined. Judge McKinley passed over them in his written opinion, stating that their status was not questioned during the hearings. . . .

At the Attorney-General's office it was explained that the ruling will not automatically compel organizations to cease practicing medicine, but that the decision, if upheld by the State Supreme Court, would be a precedent upon which the State could institute *quo warranto* proceedings against those institutions. . . .

—*Chicago Daily News,* March 22, 1935.

[Written for the American Association of Dental Editors.]

HEALTH INSURANCE MADE COMPULSORY

ONTARIO CITIES SHARE IN PLAN

Toronto, March 2.—(Universal)—Compulsory health insurance, effective next month for persons drawing direct relief, war veterans drawing small pensions, and their families in all organized municipalities in Ontario, has been announced by David Croll, Minister of Welfare of Ontario.

Under the plan the province and the municipalities will share the cost. The plan differs from the English panel system in sev-

eral particulars, and Croll described it as Canada's first step toward state medicine.

The province and the municipalities will jointly pay 25 cents for each individual and the Ontario Medical Association will undertake to provide treatment and medicine through family doctors and neighborhood chemists.

—*Toledo* (O.) *Times*, March 3, 1935.

HOUSE GROUP TO REPORT SOCIAL SECURITY BILL

Washington, D. C., April 2.—The Ways and Means Committee agreed today to report to the House the administration's Social Security Bill.

Formal action will be taken after Chairman Doughton (Dem., N. C.) introduces a new bill embodying the many amendments inserted by the committee in the original Wagner-Lewis-Doughton bill.

The informal agreement to report the measure followed a vote on a motion by Representative Cooper (Dem., Tenn) to accept as a part of the bill the sections levying taxes on pay rolls and earnings for old age annuities to workers.

His motion was supported by seventeen of the eighteen committee Democrats, with the seven Republicans voting present. Representative Lamneck (Dem., O.), who is ill, was absent.

—*Chicago Daily News*, April 2, 1935.

[Written for the American Association of Dental Editors.]

ORAL HYGIENE POLL ON HEALTH INSURANCE

This poll shows some very interesting figures. Whether they present a true cross-section of the membership of the American Dental Association or not, they show a marked trend of thinking toward socialization on the part of the profession as a whole.

It has become necessary for all dental organizations, as well as individuals, to study the many phases of the problem if they hope to be able to vote intelligently on questions that will vitally concern their financial welfare and professional relationships.

Members of this year's House of Delegates should go to the New Orleans meeting with full knowledge of how their constituents feel about the part dentistry and medicine should take in the so-called Economic Security Program.

The House must decide.

NEWS NOTE

Dr. Harry Strusser, Chief of the Dental Division, New York City Department of Health, stated that between $84.00 and $100.00 would be required to bring an adult mouth back to functional health. The doctor probably means the first cost for the needed services for the average adult.

What would be the average cost, annually or semiannually, thereafter?

[Written for the American Association of Dental Editors.]

TESTIMONIAL TO DR. OTTOLENGUI BY THE DENTAL PROFESSION

The dental profession is to express in a material sense its debt to one of the profession's most unselfish, tireless, and accomplished workers. A movement has been started to recognize the seventy-fifth birthday of Dr. R. Ottolengui through the medium of a fund to be raised amongst his many friends and admirers in the profession.

Over forty-one years of service as an editor; author of books, both dental and fiction; contributor of chapters to several recognized text-books on dentistry, lecturer, clinician, inventor, dental society officer, active worker in dental relief work and contributor of his time, thought, and personal fortune to the advancement and for the general welfare of the profession in all of its phases, he has earned the gratitude and appreciation of all who believe that unusual service merits recognition.

To those contributing $5.00 or more to this fund the committee proposes to send a copy of a special edition of Dr. Ottolengui's book, "Table Talks on Dentistry," with an engraved facsimile of the author's autograph on the first page. This and the special marking of the book will identify it and always serve as a reminder of your active participation in this well earned tribute. Please mail check or money order to the Ottolengui Testimonial Fund, 1 Hanson Place, Brooklyn, N. Y. The active participation of members of the dental profession from all over the country is anticipated. Do it now. The committee thanks you for your generous coöperation.

DR. W. D. TRACY, *Honorary Chairman.*
DR. J. R. SCHWARTZ, *Chairman.*

OTTOLENGUI TESTIMONIAL FUND,
1 Hanson Place, Brooklyn, N. Y.

I herewith subscribe the sum of $5.00 in consideration for which I am to receive an engraved autographed copy of Dr. Ottolengui's "Table Talks on Dentistry."

Name .....

Address .....

.....

Make check payable to "Ottolengui Testimonial Fund" and address to Room 1403, 1 Hanson Place, Brooklyn, N. Y.

Dr. William D. Lanier, Jr.

Dr. Sidney S. Jaffe

Dr. Samuel M. Gordon

William D. Lanier, Jr., D.D.S., Lieutenant Colonel, Dental Corps, Reserve, United States Army. Chief Dental Officer, Veterans' Administration Hospital, Oteen, N. C.

Dr. Jaffe was graduated from Georgetown University in 1905, and specializes in Full Dentures. He is a member of the District of Columbia Dental Society, the American Dental Association, the National Society of Denture Prosthetists, and the American Full Denture Society. He is a Lieutenant-Commander (Specialist Corps), Reserve Officers Dental Corps, U. S. N. He has contributed two chapters to Nichols' "Prosthetic Dentistry," namely: "Full Gold Castings" and "Immediate Denture Service." He has been a frequent contributor to the Journal of the American Dental Association and the Dental Digest on subjects of Full and Immediate Dentures. Since 1930, Dr. Jaffe has lectured and demonstrated in twenty-five states. He has made an original contribution in the "Lingual Matrix" for pre-extraction records which is most noteworthy and outstanding.

Samuel M. Gordon, B.S., M.S., Ph.D., Secretary of the Council on Dental Therapeutics of the American Dental Association. Before coming to the Association in 1928, he was a National Research Council Fellow in the Biological Sciences at the University of Wisconsin. B.S. in Chemistry from Tufts in 1922; M.S. from the University of Iowa in 1923; Ph.D. from the University of Wisconsin in 1926. In addition, he has taken special work at Harvard and at the Institute Agronomique, Paris, France. His training has been in Chemistry. In 1930 he made a survey of the patent medicine situation in New York City for the Commissioner of Health of that city. He holds a commission as captain in the Chemical Warfare Reserve; Fellow in the American Academy for the Advancement of Science; Associate Fellow in the American Medical Association; member of the American Chemical Society; member of Sigma Xi.

REPORT ON THE DENTAL CURRICULUM

For several years the dental profession has eagerly awaited the findings of the Curriculum Survey Committee of the American Association of Dental Schools. This Committee was appointed in 1930; its work has been supported by grants made by the Carnegie Corporation of New York. The Committee has now completed its investigation relating to the curriculum and has outlined a course of study in dentistry.

The Survey is an effort to adjust the program of dental education to the responsibilities of the profession. It is the first attempt of a profession, working on a national basis and using recently developed educational techniques, to outline in detail a course of study in its field. It should prove to be a credit to the progressive spirit in dental education, and the report should be of assistance to all who are interested in the problems of training men and women for the practice of dentistry. Without doubt, the discussions of dental education during the next few years will revolve around this report.

Progressive dentists are greatly concerned about dental education. More than ever before, they realize the strategic position of the dental schools for the improvement of the profession and its service to the public, and they wish to see measures taken that will strengthen the work of the schools and keep them abreast of the times. Such dentists will find in the report of the Committee much that will interest them.

The report of 425 pages, entitled "A Course of Study in Dentistry," is the most recent extensive discussion of certain features of dental education. It outlines the history and plan of the Survey, summarizes oral health conditions of the people, and describes the responsibilities of dentistry in its modern relationships. The objectives of dental education are stated; the knowledge, skill, and experience which the dental student should acquire are set forth in considerable detail; and the preliminary college education of dental students is discussed at some length. Finally, a series of recommendations are made regarding policies of dental education, which have been adopted by the American Association of Dental Schools.

A limited number of copies of the report are available for dentists who are interested and care to have them. They may be obtained at the cost of printing and distribution (paper-bound

copies at $1.00 each and cloth-bound copies at $1.50) by writing to Dr. G. D. Timmons, Secretary-Treasurer, American Association of Dental Schools, 1121 West Michigan Street, Indianapolis, Indiana.

[Editor's Note: A copy of this book was just received by me, and while I have not the opportunity to give you a comprehensive review, I can recommend it to you as a valuable addition to your dental library, after scanning through its pages to learn its contents.]

A Roadway Scene Near Blowing Rock

Golf at Blowing Rock

COMMITTEES—1934-1935

Chairmen of Committees will please make their reports to the House of Delegates in WRITING. This will prevent errors, and will save both time and money. Early reports will greatly facilitate the work of the House of Delegates.

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Dr. Harry Bear

Dr. Harry Kaplan

Dr. Arthur B. Crane

HARRY BEAR, D.D.S., F.A.C.D., Medical College of Virginia, School of Dentistry, 1913. Past-President Richmond Dental Society, Virginia State Dental Association, American Society of Oral Surgeons and Exodontists. A member of the International Association for Dental Research and Virginia Academy of Science; a Fellow of the American College of Dentists, American Medical Association, and New York Academy of Dentists. Dean and Professor of Exodontia, Medical College of Virginia, School of Dentistry. Trustee, American Dental Association.

HARRY KAPLAN, D.D.S., Georgetown University, member American Dental Association, International Association for Dental Research, Chief Dental Surgeon and Secretary of the Medical Staff, Episcopal Eye, Ear, and Throat Hospital; Clinical Instructor in Surgery, George Washington University Hospital; member Alpha Omega fraternity.

ARTHUR B. CRANE, D.D.S., University of Pennsylvania. Member American Dental Association, American Medical Association, International Association for Dental Research, formerly Professor of Oral Surgery and Research Professor of Mouth Diseases, George Washington University, formerly Chief Dental Surgeon to Garfield Memorial and Emergency Hospitals, member of Editorial Council "Diet and Dental Health," Major, U. S. Army Dental Reserve Corps, member Psi Omega dental fraternity.

HOTELS

From the list below, you will note that Hotel Accommodations are available within the reach of every one. The prices listed include meals. Please make reservations and have them confirmed so you will know exactly what you are getting.

MAYVIEW MANOR

American Plan Hotel

Double room, without bath but with hot and cold running water, daily per person	$ 4.50
Single room, without bath but with hot and cold running water, daily per person	5.00
Single room, private bath, daily per person	7.00
Double room, private bath and connecting bath, daily per person	6.00

BLOWING ROCK HOTEL

Rooms Without Private Bath

Single, daily	$ 3.50
Double, daily	4.50
Single, weekly	28.50
Double, weekly	25.00

Rooms With Connecting Bath

Single, daily	$ 4.50
Double, daily, each	4.00
Single, weekly	40.00
Double, weekly	30.00

Rooms With Private Bath

Single, daily	$ 6.00
Double, daily	5.00
Single, weekly	45.00
Double, weekly	40.00

Colored nurses and chauffeurs in Servant Quarters.

American plan, $16.00 per week; $3.00 per day.

Private garage, 75c. per day; $3.50 per week.

GREEN PARK HOTEL

American Plan Hotel

Rooms with running water, per person ..... $ 4.00
Rooms with private bath, twin beds, per person 5.00
Room with private bath, one person 6.00

HOB NOB INN

Rooms with bath, per person per day..... $3.00 to $4.50

American Plan

MARTIN COTTAGE

American Plan

Room per person per day.....$ 3.00

GENERAL INFORMATION

Registration

The registration desk will be located in the lobby of the Mayview Manor, and registration will begin at 8:00 o'clock Monday morning. The system of registration in vogue during the last few years will be used again this year, viz., members will register with their respective district secretaries, who will be present for that purpose, and for collecting dues from any who might have overlooked that detail. Members will receive individual badges, upon which they are to write their names.

Visiting members of the A. D. A. will receive a Guest Badge upon registering and presenting their 1935 membership card.

Dental students are welcome and will receive a Guest Badge upon presentation of a certificate from their college.

Badges will be issued to representatives of firms exhibiting at the meeting.

Members may register and procure Guest Badges for their wives and members of their immediate families by filling out a card and affixing their signature.

General Sessions and Lectures

All general sessions will be held in the ballroom of the hotel, and out of courtesy to our lecturers, members are urged to be in their seats on time and remain until the meeting is adjourned.

The usual formal discussions will be omitted; but our schedule is arranged with the view of allowing time for a brief classroom discussion with questions and answers, which seems to be a more practical method of bringing out desired information.

Clinics

All clinics will be held on Monday afternoon. Those employing the stereopticon or motion pictures, or requiring the presence of a patient in the presentation of same, will be located in separate rooms, as indicated in the program; all others will be located in the ballroom.

Banquet

For all who are registered at the Mayview Manor (being American plan), there will be *no extra charge for attending our annual banquet.* Those stopping at other hotels may register for the banquet with the clerk at the Mayview Manor, for which a charge of only $1.00 will be made. All those registered at the convention are cordially invited to attend.

Dance

There will be a charge of $1.00 per person for the dance. Tickets may be obtained from the hotel clerk.

Entertainment

(Preliminary Announcements)

Golf Tournament will open Sunday afternoon, June 16. The course is in excellent condition, and those entering should have a grand time. A number of prizes will be awarded. Those desiring to play should contact Dr. Dennis S. Cook, Lenoir, N. C.

There will be a bridge party for the ladies, as well as horseback riding, scenic trips, golf, etc. For the men there will be fishing, golf, scenic rides, and other entertainment.

Committee Reports

Chairmen of committees will please make their reports to the House of Delegates in writing. This will prevent errors, and will save both time and money.

Officers' Conference

The attention of all the officers of the State society and the district societies is called to the breakfast conference, scheduled for Tuesday morning at 7:30 o'clock; and it is urged that all officers attend. Our President-elect will preside over the meeting. It will be short and snappy. Come prepared to discuss anything you wish so long as you make it brief.

PRELIMINARY
PROGRAM
NORTH CAROLINA DENTAL SOCIETY

MAYVIEW MANOR

Blowing Rock, N. C.

June 17, 18, 19, 1935

MONDAY MORNING, JUNE 17TH

8:00 A.M.

REGISTRATION—(Lobby) Mayview Manor.

9:00 A.M.

OPENING SESSION—(Ballroom).

INVOCATION . . . *Rev. Sexton Buchanan*, Blowing Rock, N. C. (Pastor Presbyterian Church)

ADDRESS OF WELCOME . . . . . Mayor of Blowing Rock, N. C.

PRESIDENT'S ADDRESS . *Linus M. Edwards, D.D.S.*, Durham, N. C.

REPORT OF NECROLOGY COMMITTEE—
Phin E. Horton, D.D.S., Chairman, Winston-Salem, N. C.

REPORT OF DISTRICT TRUSTEE, AMERICAN DENTAL ASSOCIATION—
Harry Bear, D.D.S., Richmond, Va.

10:30 A.M. to 12:30 P.M.

"PYORRHEA ALVEOLARIS"—Illustrated Lecture.
Arthur B. Crane, D.D.S., and
Harry Kaplan, D.D.S., Washington, D. C.

SYNOPSIS—This will be a study of the normal anatomy and histology of the teeth and their supporting structures, with especial emphasis upon the manner in which departures from the normal become causative factors in the establishment of pyorrhea alveolaris. The etiology of the disease will be fully discussed in such a manner as to bring out the most successful preventive measures. There will be a full consideration of the early and progressive clinical symptoms of pyorrhea alveolaris and a comprehensive system of radiographic diagnosis will be presented. A histopathological study of over fifty block sections taken from living subjects will be shown by photomicrographs and will definitely prove the nature of the disease.

12:30 P.M. to 1:00 P.M.

MEETING OF HOUSE OF DELEGATES.

1:00 P.M.

LUNCH.

MONDAY AFTERNOON, JUNE 17TH

CLINICS

2:00 P.M. to 5:00 P.M.

DEMONSTRATION CLINICS

(Private Dining Room—First Floor)

"FULL DENTURES"—Illustrated with motion pictures.

L. G. Coble, D.D.S., Greensboro, N. C.

SYNOPSIS—Denture construction with only one appointment between the impression and the finished denture, with three positional bites on plane line articulator. Spot grinding done in laboratory and not in the presence of the patient. Illustrated with motion pictures.

(Sun Parlor)

"FULL LOWER IMPRESSION TAKING"—with patient present.

Ralph F. Jarrett, D.D.S., and
J. R. Bell, D.D.S., Charlotte, N. C.

SYNOPSIS—(1) Good snap impression.
(2) Properly adapted impression tray.
(3) Full compound impression with correctly placed stress and muscle trimming.

(Room 30)

"PRACTICAL PROCEDURE IN FULL DENTURE CONSTRUCTION, WITH PARTICULAR REFERENCE TO SECURING THE BITE AND FUNCTIONAL OCCLUSION"—Illustrated with motion pictures.

A. M. Hitt, D.D.S., Salem, Va.

SYNOPSIS—A method of denture construction for the general practitioner with special reference to bite and occlusion, using nature's own articulator. A procedure by which any dentist with average mechanical ability can produce dentures that will be comfortable and efficient—without the necessity of geometrical romancing—substituting common sense. Actual cases illustrated with movies.

(Bar Room—First Floor)

"THE VALUE OF ETHYL CHLORIDE IN CHILDREN'S DENTISTRY"—
Illustrated with motion pictures.

H. A. Edwards, D.D.S., Greensboro, N. C.

SYNOPSIS—Short paper which covers briefly, admission of patient to the office, preparation of the **parent**, history of patient, examination, and method of administering ethyl chloride as a general and local anesthetic. Ten practical cases illustrated by four hundred feet of motion pictures.

GENERAL CLINICS

(Ballroom)

"An Anomaly in Dentition"—*O. R. Hodgin, D.D.S.*, Thomasville, N. C.

SYNOPSIS—Presenting the case of a man, 26 years of age, who has lost his normal teeth and wearing artificial dentures, and now has thirty fully formed unerupted supernumeraries in the two arches; case history; extra-oral radiographs 11" x 14" of entire head, both right and left views, also anterior-posterior; several occlusal exposures using the 2¼" x 3" films, as well as the entire arch with the regular small films, giving in each set different angles.

"Cast Partial Denture Construction"—
Arthur P. Little, D.D.S., and
C. W. Morhart, D.D.S., Richmond, Va.

SYNOPSIS—This clinic will show the steps in constructing a cast partial denture from the impression to the finished cast frame. In addition to this, an attempt will be made to demonstrate certain bio-engineering principles involved. Considerable time will be spent on the matter of proper design for various types of partial dentures and on the various phases of case planning.

"Cast Restorations for Deciduous Teeth"—
Horace K. Thompson, D.D.S., M.S., Wilmington, N. C.

SYNOPSIS—Using Willett's cavity preparation, demonstration of quick and easy way of taking impression and making inlays by indirect method, from stone models sectioned.

"Gold Inlays and Bridge Abutments"—
W. R. Hinton, Jr., D.D.S., Greensboro, N. C.

SYNOPSIS—This clinic embraces the various types of inlays and bridge abutment pieces showing both the standard box type and also the slice and pin ledge preparations. Among these will be exhibited a series of the MacBoyle attachment, demonstrating the different types and indications for each. A number of gold castings on natural teeth will be displayed, showing the various preparations and indications, supplemented with large plaster models which which will show the preparation more in detail.

"Fractures of Mandible" . *Wm. D. Lanier, Jr., D.D.S.*, Oteen, N. C.

SYNOPSIS—A simplified wiring technic, illustrated with radiograms of practical cases and models

"Baked Porcelain" . . *Sandy C. Marks, D.D.S.*, Wilmington, N. C.

SYNOPSIS—This clinic shows the steps in the preparation and construction of porcelain jacket crowns and inlays.

"Elimination of the Periodontal Pocket"—
Dan B. Mizell, D.D.S., Charlotte, N. C.

SYNOPSIS—Is there a universal method applicable to all treatments? Is the goal, toward which you are striving, simply relief from symptoms, or is it the raising of tissue health? Of the three main variations of teachings, which do you use and why?

1. Radical gingivectomy.
2. Conservative surgery.
3. Conservative curettage.

These will be illustrated by drawings and original photographs showing before and after treatment.

"Practical Exodontia, and the Control of Dry Sockets"—
Harold E. Story, D.D.S., Charlotte, N. C.

SYNOPSIS—This clinic will cover: The selection of instruments for certain cases; the importance of proper diagnosis, and the benefit of good radiograms for operating; the consideration of proper medication to meet certain conditions.

"Impression Taking for the Construction of Full Dentures"—
G. W. Yokeley, D.D.S., Winston-Salem, N. C.

SYNOPSIS—Demonstration of how compression of the soft tissues and proper relief of osseous tissues with the impressions, secure a more preferable adaptation for the denture.

"Practical and Efficient Fixed-Movable Bridgework"—
L. M. Daniels, D.D.S., Southern Pines, N. C.

SYNOPSIS—Method of placing a fixed bridge so as not to interfere with the normal physiological movements of the abutment teeth, and where the insertion of a bridge on malposed teeth is no longer a problem.

"Quick Plate Repair; and Cast Backings for Steele's Facings"—
J. S. Frost, D.D.S., Burlington, N. C.

SYNOPSIS—Demonstration of an accurate and practical way to reproduce and replace posterior teeth on artificial dentures within fifteen minutes, using synthetic porcelain. Also a technic for casting backings for Steele's facings, in which scrap gold may be used

"Taking the Bite, Nature's Way"—
L. G. Page, D.D.S., Yanceyville, N. C.

SYNOPSIS—A short comprehensive idea of taking the bite only—one of the most important fundamentals in the construction of artificial dentures.

"Practical Hints in the Treatment of Fractured Jaws"—
P. B. Whittington, D.D.S., Greensboro, N. C.

SYNOPSIS—An effort will be made to demonstrate two very practical methods for fixation of mandibular and maxillary fractures or both The marked effect of the masticatory muscles on the displacement of mandibular fragments will be pointed out. The treatment to be discussed for mandibular fractures will be intermaxillary wiring. The method for the maxillary fractures will be a combination of intermaxillary wiring and a rubber suspension under the chin by using plaster headgear for cranial attachment.

"Our Method of Determining the Pathologic Condition of the Blood in Its Relation to Dentistry"—
O. C. Barker, D.D.S., Asheville, N. C.

SYNOPSIS—Demonstration of taking a patient's hemoglobin percentage, of preparing and staining slides of bacteria and blood smears, making quantitative counts of both red and white corpuscles, also the differential count of the white cells.

"Intercepting Mal-Occlusion by the General Practitioner"—
R. Philip Melvin, D.D.S., Winston-Salem, N. C.

SYNOPSIS—"It is the purpose of this clinic to present to the general practitioner some practical methods of preventing mal-occlusion by use of space makers and maintainers, and by advice and instruction to the parent."

"Study Models and Check Bites in Dealing With Occlusal Stress"— . . . *W. F. Clayton, D.D.S., High Point*, N. C.

SYNOPSIS—In view of the fact that in occlusal stress each case must be studied and treated individually and not as a type, and that extrusion of certain teeth especially the molars make the mouth examination so misleading and almost impossible, so far as forming a definite picture in the mind of the existing condition, and the possibility of relieving same. The use of study models mounted to centric, right and left lateral bites, when properly carried out will unquestionably locate extrusion and materially aid in studying the possibilities of restoring a normal functional occlusion.

"Treatment of Deep Periodontal Lesions"—
S. P. Gay, D.D.S., Waynesville, N. C.

SYNOPSIS—Classification of periodontal lesions into seven types demonstrated by radiograms:

Methods of treatment
1. Modified flap operation.
2. Gum excision technique.

Demonstration of methods by which the patient can care for difficult lesions.

"Restoring Badly Abraded Natural Teeth to Their Original Function and Occlusal Relations"—
John A. McClung, D.D.S., Winston-Salem, N. C.

SYNOPSIS—1. Making the diagnosis and survey.
2. Establishing the original occlusal relations.
3. A method of maintaining the established functional occlusal relations throughout the process of restoring the individual teeth.
4. Articulated casts will show the case before and after treatment.

"Extractions" . . . . *N. P. Maddux, D.D.S.*, Asheville, N. C.

SYNOPSIS—There will be an endeavor made to show how and the amount of bone removed before the tooth or teeth are removed from their sockets. Also the pre- and post-operative care of the field of operation.

"Orthodontic Periodontia" . *W. D. Gibbs, D.D.S.*, Charlotte, N. C.

SYNOPSIS—By the use of full upper and lower natural teeth imbedded in plaster models, it is intended to show: (1) That certain mal-directional stresses upon the teeth surfaces tend to open contacts, producing and perpetuating the so-called food pack; (2) that correct and judicious grinding of certain teeth surfaces will close these spaces, eliminating the necessity for inlays and other restorations; (3) that contacts may be opened as well as closed by the same principle. Also drawings will be used to illustrate normal and abnormal directional stresses. This procedure has a very practical application in certain types of periodontal lesions, inasmuch as any technic is without permanent value unless the etiologic factor, or factors, be removed.

"Reviewing by Model Some Points About Bridgework"—
Howard L. Allen, D.D.S., Henderson, N. C.

SYNOPSIS—Demonstration of the up-to-date methods of restoring missing teeth with fixed bridgework, emphasizing some points that are often overlooked by the profession.

"Crown and Bridgework" . *A. W. Craver, D.D.S.*, Greensboro, N. C.

SYNOPSIS—Reasons for modifying the preparations for inlays and three-quarter crowns used as abutments; the channel-slice preparation for inlays; a method for casting Orton crowns; Peck's method of matrix construction and manipulation of wax.

"All Porcelain Posterior Dummies, Fixed-Movable Bridgework, and Cast Gold Shell Crowns"—
Frank O. Alford, D.D.S., Charlotte, N. C.

SYNOPSIS—This clinic demonstrates the use of Davis crowns, Tube teeth and Tru-bridge teeth in the construction of fixed and fixed-movable bridgework, eliminating show of gold on occlusal surfaces of dummies; the method of casting a ball and socket joint in fixed-movable bridges; the waxing and elimination of wax inside the wax pattern for cast gold shell crowns, which insures a better fit.

"Incisal Angle Restorations With Plastic Porcelain"—
Cary T. Wells, D.D.S., Canton, N. C.

Monday Evening, June 17th

8:00 P.M. to 10:00 P.M.

"Pyorrhea Alveolaris"—Illustrated Lecture.
Arthur B. Crane, D.D.S., and
Harry Kaplan, D.D.S., Washington, D. C.

SYNOPSIS—Various methods of treatment will be considered. This will include prophylaxis treatments, diets, radiation, Dunlop method, chemico-bacteriologic method, sub-gingival curettage, flap operation, and the Crane-Kaplan Operation.

Tuesday Morning, June 18th

7:30 A.M.

Officers' Conference—Breakfast.

9:00 A.M. to 10:30 A.M.

"A Technic for the Construction of Full Upper and Lower Dentures, Which Will Require No Corrections or Adjustments When Once Inserted"—Illustrated Lecture.
Sidney S. Jaffe, D.D.S., Washington, D. C.

SYNOPSIS—Dr. Jaffe will go over the entire technic showing, through slides, step by step, the construction of a full upper and lower denture, followed by moving pictures of a practical case.

10:30 A.M. to 12:30 P.M.

"Pyorrhea Alveolaris"—Illustrated Lecture.
Arthur B. Crane, D.D.S., and
Harry Kaplan, D.D.S., Washington, D. C.

SYNOPSIS—Various post-operative measures which are necessary for success will be considered. This will include the use of the brush for gum massage, the balancing of occlusion, the factors in restorative procedures which encourage the growth of normal tissue. Interpretation of radiographic check-ups and a study of photomicrographs made from block sections of healed cases will also be presented.

1:00 P.M.

Lunch Hour.

Tuesday Afternoon, June 18th

2:00 P.M. to 3:30 P.M.

"The General Scope of Products Considered by the Council on Dental Therapeutics"—

Samuel M. Gordon, Ph.D., Chicago, Ill.

SYNOPSIS—Dr. Gordon's talk will discuss in some detail the work of the Council on Dental Therapeutics and of the A. D. A. Bureau of Chemistry, and how this work is intimately bound up with the every-day practice of the dentist. It is hoped to show the members of the North Carolina Dental Society that materia medica and therapeutics are not the dry and uninteresting subjects that many think they are. They have an interest that affects the dentist and patient alike.

The work of the council will be illustrated by reference to some of the tooth bleaches on the market sold to both dentists and laity for the bleaching of teeth; their composition and dangers of use will be pointed out. Pyorrhea remedies will be discussed. Pulp capping materials will be discussed in some detail with particular reference to their purchase under proprietary names, showing how dentists have been inveigled into paying $72.00 for about 50c worth of material. Suggestions will be made for the use of the well-known products listed in the Pharmacopeia and in Accepted Dental Remedies. Following this, local anesthetics will be discussed, with particular reference to topical anesthetics sold under proprietary names, and stock solutions of procaine hydrochloride sold to dentists with particular reference to the preservatives contained therein and suggestions for the preparation of these by the dentist himself or by the pharmacist on his prescription. Whenever possible, concrete suggestions will be given. Finally, ready-made pain relievers and how their unwitting recommendation by the dental profession leads to an alarming degree of undesirable self-medication will be discussed, with suggestions as to how the dentist may satisfactorily prescribe these compounds.

NOTE—Dr. Gordon says, "I shall be disappointed if it does not stimulate a number of questions on the part of the audience after I am through with the regular part of my talk. In the past appearances, I have found this to be the most interesting part of the meeting." It may be that members of the society have in mind some drug product or proprietary product in which they are especially interested, and which they would like to have Dr. Gordon discuss. If so, they are invited to submit such questions in writing to the Secretary as early as possible; and if enough questions of this type are received, Dr. Gordon plans to devote part of his lecture period Wednesday morning answering them.

3:30 P.M. to 5:00 P.M.

"Stabilization of Flat Lower Dentures"—Illustrated Lecture.

Sidney S. Jaffe, D.D.S., Washington, D. C.

SYNOPSIS—Dr. Jaffe will dwell on the reasons why a lower denture gives trouble, and will give a definite method for stabilization and an improved method for taking lower impressions.

This is based on an entirely new principle, and as far as he has been able to learn it is quite new; at least, he has never known any one to use the method nor has he seen any reference to it in dental literature. He also finds that patients with fairly good ridges claim the use of this technique makes ordinarily comfortable dentures a great deal more comfortable.

5:00 P.M.

Meeting of House of Delegates.

TUESDAY EVENING, JUNE 18TH

6:30 P.M.

BANQUET.

Address.

Presentation of President's Emblem.

8:30 P.M.

GENERAL SESSION.

Election of Officers.

Election of Two Members to the Board of Examiners.

Election of Delegate and Alternates to A. D. A.

Selection of Place for next Meeting.

10:00 P.M.

DANCE—Ballroom, Mayview Manor.

WEDNESDAY MORNING, JUNE 19TH

9:00 A.M. to 10:30 A.M.

"IMMEDIATE DENTURES"—Illustrated Lecture.

Sidney S. Jaffe, D.D.S., Washington, D. C.

SYNOPSIS—Dr. Jaffe will give a lecture of the entire technic, and the reasons for Immediate Dentures, followed by moving pictures of the complete technic.

10:30 A.M. to 12:00 NOON

"PRE- AND POST-OPERATIVE MEDICATION FOR DENTISTS AND ORAL SURGEONS" . . . *Samuel M. Gordon, Ph.D.*, Chicago, Ill.

SYNOPSIS—Pre- and post-operative medication for dentists and oral surgeons will be discussed in some detail. It will be shown how dentists may rid themselves of handing out shot-gun mixtures for the relief of pain, and how they may intelligently and practically use the well-known drugs which are available for this purpose.

12:00 NOON

MEETING OF HOUSE OF DELEGATES.

GENERAL SESSION.

INSTALLATION OF OFFICERS.

ADJOURNMENT.

DISTRICT SOCIETIES

DISTRICT OFFICERS AND DELEGATES, 1934-35

First District

President.....J. F. Reece, Lenoir
President-Elect.....O. C. Barker, Asheville
Vice-President.....S. E. Moser, Gastonia
Secretary-Treasurer.....Chas. S. McCall, Forest City
Editor.....A. D. Abernathy, Jr., Granite Falls

Delegates.....
- J. F. Reece, Lenoir
- Chas. S. McCall, Forest City
- C. B. Mott, Morganton
- T. A. Wilkins, Gastonia
- R. R. Howse, Forest City

Second District

President.....F. O. Alford, Charlotte
President-Elect.....J. H. Nicholson, Statesville
Secretary-Treasurer.....W. C. Current, Statesville
Editor.....T. P. Williamson, Charlotte

Delegates.....
- F. O. Alford, Charlotte
- W. C. Current, Statesville
- E. S. Hamilton, Charlotte
- Harry Keel, Winston-Salem
- D. O. Montgomery, Statesville

Third District

President.....T. E. Sikes, Greensboro
President-Elect.....E. M. Medlin, Aberdeen
Vice-President.....C. D. Kistler, Randleman
Secretary-Treasurer.....C. A. Graham, Ramseur
Editor.....D. T. Carr, Durham

Delegates.....
- T. E. Sikes, Greensboro
- E. M. Medlin, Aberdeen
- C. A. Graham, Ramseur
- J. H. Hurdle, Mebane
- L. G. Page, Yanceyville

Fourth District

President.....G. L. Hooper, Erwin
President-Elect.....J. R. Edwards, Fuquay Springs
Vice-President.....Everett L. Smith, Raleigh
Secretary-Treasurer.....L. J. Moore, St. Pauls
Editor.....R. M. Squires, Wake Forest

Delegates.....
- G. L. Hooper, Erwin
- L. J. Moore, St. Pauls
- J. R. Butler, Dunn
- G. Fred Hale, Raleigh
- R. M. Squires, Wake Forest

FIFTH DISTRICT

President.....PAUL FITZGERALD, Greenville
President-Elect.....M. B. MASSEY, Greenville
Vice-President.....A. L. WOOTEN, Greenville
Secretary-Treasurer.....W. L. HAND, New Bern
Editor.....A. M. SCHULTZ, Greenville
Delegates.....PAUL FITZGERALD, Greenville
W. L. HAND, New Bern
Z. V. PARKER, New Bern
H. L. KEITH, Wilmington
FRED HUNT, Rocky Mount

FIRST DISTRICT

FIRST DISTRICT NEWS AND VIEWS

When served notice that it was time to send him the news of First District, Dr. Hale stated that he was sure we had something to say concerning our splendid section. We have. In fact, since it would be impossible to say much without sounding like a real-estate salesman or a chamber of commerce press agent, we will, in lieu of statements, challenge every ethical dentist in our good North State to come to the meeting in Blowing Rock the 17th, 18th, and 19th of June and see for himself. You will not be disappointed clinically, fraternally, or climatically.

Continuing that very fine objective of making First District first, the past year was one of distinct advancement—climaxed by the meeting held in Rutherfordton, which fulfilled the paramount purposes of all meetings—instruction and the promotion of good fellowship. Outstanding among the clinicians was Dr. Stuart Kabnick's technic on Root Canal therapy. This phase of dentistry seems to be largely neglected, although it will be generally admitted that the natural tooth, if physiologically and esthetically retained, is better than an artificial substitute.

Another bouquet might be tossed at our society within a society, the Tri-County, composed of Caldwell, Burke, and Catawba counties, meeting once a month there was not a dull moment. The programs to develop friendly feelings and coöperation between the medical and dental professions were of special importance in the advancement of public health and the placing of dentistry in the field of preventive medicine, where it rightfully belongs. Another outstanding program was furnished through the courtesy of one of the dental supply houses (Powers and Anderson), on the economic side of dentistry, and included office management. The dental assistants were present for this instruction.

The study club held in Asheville was another step in this program to keep the dental practitioner in First District as alert, as familiar with new technic, and as capable of rendering the best service as is possible. More of this type of study is absolutely indicated.

Our district was saddened this fall by the death of Dr. J. M. Gaither, who was a fine dentist and a Christian gentleman. His spirit and the

fine ideals for which he stood will go marching on in First District endeavors.

So, with the country still in turmoil, with the public not sure the corner we have reached is the proverbial one around which prosperity has been hiding these past few years, it is our duty to spread optimism, to study, to build towards, to think and plan for organized preventive dentistry. This millennium will only be reached by individuals coöperating in societies—the National, State and, more intimately, the District. There you meet the best men in this profession you have chosen to gain your sustenance—men who are striving to leave dentistry better than it was when they entered—men who are putting more into their profession than they are getting from it in service to humanity. Success will come not by socialized, commercialized panel dentistry, destroying initiative and ideals and worshipping a god of gold, but in honest to goodness, downright individualism, fostered and kept modern by your dental society.

We are expecting you *all* in Blowing Rock. You will benefit professionally and fraternally, and up here in God's blue mountains perhaps gain new courage to fight an even better fight. May the ghosts of all those great-hearted men who sacrificed to put dentistry where it is today rise up and haunt you if you don't check in at Blowing Rock on the 17th! Let's *you* be able to say, "We do our part." I'll be seeing you in the land of the sky——

Some men are born great, some achieve greatness, and some have greatness thrust upon them. We who are members of the First District belong to the second group; we have achieved greatness, for the North Carolina Dental Society will meet with us this year. We feel keenly the honor that comes to us with this privilege of acting as host to our fellow workers. But where honor is, there is also responsibility. We cannot feel the thrill of pleasure that comes to us as we anticipate this meeting without feeling too a sense of acute responsibility. Fellow members of the First District, it's up to us to make this meeting a pleasant and profitable one. Assuming this responsibility which evolves upon us, let me urge every one of you to make your plans now to be present at the meeting in Blowing Rock on June 17, 18, 19, to extend the hand of greeting and fellowship to those who come from other districts.

To those outside of our district I would say this: Our State is unusually blest with a variety of climate, scenery, and industry. Our friends of the East listen to the lashing waves of the Atlantic and watch the schooners and fishing boats come in and out. In the Piedmont section, where industry has been so highly developed, one listens to the hum of the spindles and looms. As we approach the western part of the State we are no longer attracted by the powerful roar of the sea or by the incessant hum of the spinning frame. In the land of the sky we are impressed by what we see rather than by that which we hear. Truly, Mother Nature must have been in a very artistic mood when she painted our North Carolina mountains. This wonder of scenic beauty is yours, my friends of the East, just as the plains and the sea are ours.

Our National Park to Park Highway will intersect the Blowing Rock section. Once this is completed, our State will become a Mecca for tourists from all parts of the world. Why do I tell you all of this? In order that you may have some vague idea of the allurement of this section of the State, where our 1935 convention is to be held. Won't you pack your bag and baggage and take advantage of the pleasure which awaits you? Let's take the advice of the man of yesteryears, who said, "Go West, young man, go West." We shall do our best to make this meeting outstanding for its instruction, fellowship, and enjoyment. *ON TO BLOWING ROCK!*

J. F. Reece,
President, First District.

SECOND DISTRICT

"SOME BRIEF MENTION OF THE DOINGS IN THE SECOND DISTRICT"

Not so far away now is our annual State meeting, to be held in Blowing Rock on June 17, 18, and 19, and we are looking forward to a great crowd of "Our Boys" being there.

The program, I am sure, will justify your presence, and the few day's out of the office to mingle with the "Fellows," and at the same time gain scientific knowledge to bring back home, will be a help to us all in many ways. The mountains should be a most delightful place to meet, and no one need fear that the weather will be any too hot there. So, right now, mark off the above dates on your appointment book; make your arrangements to come, and stay throughout the entire meeting.

Our local dental society (Charlotte) has had a most interesting year. Dr. Wallace Gibbs, the president, did good work in appointing Dr. Harold Story as program chairman. Both the clinics and papers have been of a most interesting nature. Some of the clinicians and essayists that have appeared before us include: Dr. Charles De-Forest Lucas, who spoke on malignancy of the mouth. Dr. Sylvia Allen brought us a most interesting address on "Frontiers of Psychiatry," in connection with the mental hygiene clinic that is in operation here. Both of these physicians are residents of our city, and each is doing a great work in his respective field. To our delight we have had with us Dr. Richard L. Simpson, A.M., D.D.S., F.A.C.D., of the Medical College of Virginia. Dr. Simpson brought us a splendid address on economics, and also discussed some of the newer materials used in prosthetic dentistry.

The recent meeting in Atlanta of the Southern Academy of Peridontology was conducted exclusively by Dr. Wallace Gibbs.

Dr. Frank Alford is program chairman of the alumni meeting to be held in Atlanta in May.

Dr. Amos Bumgardner and Dr. Wallace Gibbs are on the program for April 17 of the Central District Society of South Carolina.

Dr. B. N. Walker, of Meridian, Mississippi, has moved to our city, and we extend to him a most cordial welcome into our ranks.

Dr. Gary Hesseman is the luckiest man in town now, for just recently has appeared the announcement of his approaching marriage to Miss Brantley Nichols, of Charlotte and Chester, South Carolina.

Dr. Dan Mizell, who suffered a very serious injury to his leg some time ago, is much improved, we are happy to say, and we hope that soon he can be entirely well.

"All Aboard for Blowing Rock."

T. P. Williamson,
Editor, Second District.

WHY WE SHOULD SUPPORT THE FIVE STATE POST-GRADUATE CLINIC

The membership of the North Carolina Dental Society received a program of the recent meeting of Five-State Post-Graduate Clinic, held at Wardman Park Hotel in Washington, D. C., March 18-20, so it is needless to stress the quality of the instructions given at this meeting. I would like to say that it was, without a doubt, the best, most instructive meeting I ever attended, not excepting the meetings of the American Dental Association. One did not get any better program at this meeting than that by the American Dental Association, but the program was so arranged that one could attend every session and not miss anything presented. Each of the five states participating was well represented and it was gratifying to see so many from North Carolina in attendance. The registration, so I am informed, exceeded sixteen hundred, with many present who did not register.

The District of Columbia Dental Society originated this clinic and, through courtesy, invited us, as members of the North Carolina Dental Society, to participate in the meetings and reap the benefits of their efforts. It is the first time our Society has ever had an opportunity to take a part in anything quite so large, that would meet consistently within reach of every one of us. It is without cost, except expenses while attending the meeting. There is no membership fee and all that is required of those in attendance is to be in good standing in their respective Dental Societies. The Essayists, Clinicians and Lecturers are outstanding men in their particular field of endeavor and the best that the country has to offer is placed at our finger-tips, if we will only go to receive it. This organization has the most potential possibilities of any dental organization in the country and we have handed to us all of the privilege it has to offer, so it is the duty of every member of the North Carolina Dental Society to give the meeting 100 per cent support. We owe it to the District of Columbia Dental Society, the North Carolina Dental Society, and to ourselves, to attend the meetings and derive the benefits therefrom. I hope that the men from North Carolina will, next year, increase our past attendance 100 per cent or more, and I hope to see every member of the Second District Dental Society in attendance. I assure you that you will not be disappointed.

Another thing, do not forget that Blowing Rock is within a hundred miles of every member of the Second District Dental Society, so let's all go. You will see old friends and get much benefit from the meeting.

Frank Alford,
President, Second District.

THIRD DISTRICT

In just a few weeks we will have an opportunity to attend another State dental meeting. Profiting from past experiences, you may be sure that we will have the very best program that can be arranged. Facts will be brought out that will answer those questions you have been confused about, and you have ideas and ways of doing things that we want to hear. Our present officers and program committee are planning a meeting that will be an education and a delight to you. Be sure to make your plans now to attend, and let nothing disturb them. Mark your calendar and watch the date. Let's make this the biggest, happiest, and most profitable meeting we ever attended.

What we need most is a better understanding of each other's problems and, above all, an understanding of the problems of the dental profession as a whole. The only way this can be done is to get the fellows to the meeting. Let none of the handicaps of the past years keep you away. We all love a good time, so let's work to get the clan together 100 per cent strong. Don't delay. See the members of your local society and induce them to attend. Also, write immediately to friends whom you are especially anxious to see at the meeting. If this is done, I am sure we will have the best meeting the North Carolina Dental Society has ever held. DANIEL T. CARR.

To the Third District Dental Society:

When you get this BULLETIN it will be only a few days before the State meeting at Blowing Rock, North Carolina. There is not a more beautiful spot in North America. The laurel and rhododendron on the lofty mountain peaks will be budding, and its sweet aroma flowing softly by your nostrils, incidentally, which smells better than a dental office, will cause you to divert your mind into other channels of thought, and once you cast your eyes upon these beautiful scenes, they are never to be forgotten.

Make your arrangements to be in Blowing Rock in June. Get busy and bring that non-member and the fellow who has dropped out of the society, either through indifference or is delinquent—get him by the arm and bring him along.

Seriously, gentlemen, there must be something done about the membership of our society. One man cannot stem the tide and build up the membership of this district, nor can your officers alone. It must be done by personal contact. You have a friend, bring him in: your friend has a friend, and he can bring him into the society, and in this manner build up the membership of the society.

I am told that our State membership is below 70 per cent. This is terrible, for it is under our quota, and we must have seventy-four new members throughout the State in order to reach our quota. This condition cannot go on. Think of the forces that are at all times trying to disrupt and tear down our profession, its high ideals, its standard of work, its contribution to science, and its great aims in serving the public.

Someone will say: "Well, that's through ignorance." Of course, we haven't educated the public, granted, but our best instrument is to fight these forces and educate the public through organized dentistry. Let's make a valiant fight to get our men together, and when this has been done, fight to keep them together in order that we may carry on and preserve for all times the high ideals of our profession.

The Third District last year had the largest membership in its history. Let's strive to increase its membership to at least 97 per cent this year. There are certain conditions existing in this district which prevent a 100 per cent membership, but we can do 97 per cent, and that will be a splendid batting average.

I'll be seeing you on my old stamping ground.

T. E. Sikes,
President, Third District.

No man ever lost anything by attending our State meetings, but he gained worlds of knowledge, encouragement, and confidence enabling his skill to reach that superb point of perfection which every dentist owes to those who put their utmost confidence in him. Every man who attends the lectures and clinics is made a better dentist by keeping abreast with all the new discoveries in our fast-growing science.

It is my earnest desire to see every man from the Third District at our next meeting; also, to have 100 per cent membership of all eligible dentists in the district. This is possible if every individual would put forth an honest effort to talk to the non-members in person and show them that together we stand and divided we must fall.

Never before in the history of the society has it been as imperative for 100 per cent membership as it is now. I sincerely hope our membership committee will contact every eligible dentist in the district and show him how he cannot afford to remain indifferent at a time when dentistry needs a solid front to carry us through the fight we are now facing. Have some live worker in each county to see every man personally and lay the facts before him. Show them that every advance in the profession has been made through organization. Show him he can ill-afford to miss the advantages which go with membership in the society. This cannot be accomplished single-handed. It will require active service of each and every one. Let me urge every member of our society to strive with all his might to see that every eligible dentist becomes a member. When we reach this stage our troubles will be at an end. We now have the best State dental laws of any state in the Union, and dentistry is on a higher plane as a result of this. The only way we can keep this is by working together. Let us all work together and, if necessary, fight together for our high ideals, and when we are thus organized we may enjoy the happy reflections earned from a well-organized society, and then work in peace and harmony. Then, and only then, will we all be able to give our best.

C. A. Graham, D.D.S.,
Secretary-Treasurer, Third District.

FOURTH DISTRICT

JOY IN WORK

Any man does his best work when he enjoys it, and the way to enjoy it is to do it thoroughly and skillfully.

In our profession, the job well done gives service and satisfaction to the patient, of course; but, more than that, it brings to the operator that happiness in toil which only those can know who look upon their handiwork and find it good. Therefore, everything that helps us to make our best work even better, not only contributes to the well-being of those whom we serve, but adds immeasurably to our own happiness. Since this is true, our best becomes an ever-advancing goal that can be most successfully pursued by putting into practice what we learn at the dental meetings and from the research findings of our profession.

The officers and committees of our State society have prepared an excellent program for our help and inspiration at Blowing Rock, June 17-19. There we shall have the opportunity of making our good better and our better best, and of enjoying a delightful vacation and the renewal of friendships.

Can we find anywhere a place better fitted to inspire and uplift our souls, to enrich our lives for better and happier work, than Blowing Rock, where is spread out for our meditation and delight a rare bit of heavenly beauty!

R. M. SQUIRES.

The time for the State meeting in Blowing Rock draws near, and I feel that we should take stock of ourselves and see if we are doing our best for those who trust to us the care of the mouth.

During the last few strenuous years I feel that we are too prone to pass up the opportunities for keeping fit for the services we are trying to render. Dentistry is advancing, and we cannot hope to keep pace without the advantages these meetings afford.

Mankind is helped in its progress almost as much by the study of imperfections as by the contemplation of perfection.

The practice of dentistry is conducted not solely at the chair. It is also conducted in the business office, in the laboratory, in the street, at meeting places, at lectures, and in reference books. To be able to give our patients that which is considered the highest type of service, we must perfect ourselves by our reference at all times to past and present developments in our profession and in our current existence.

The North Carolina Dental Society ranks with the best, the attendance is always good, the programs are instructive, and the fellowship is inspiring. I am sure this meeting will equal any we have had before, so let's plan to take this in and view the grandeur of Western North Carolina again, as well as receive the helpful hints that these contacts afford.

L. J. MOORE, D.D.S.,
Secretary, Fourth District.

Two months from now dentists from all parts of North Carolina, besides those from other states, will descend upon Blowing Rock for the 1935 annual meeting of the North Carolina Dental Society. A study of the program published in this issue tells the story.

There will be hundreds there to make the meeting a success, but it will not be all that it should unless all are there to do our part, and also to get what we rightfully should have. Too long have we been content to let the meeting go by with the remark that we would try to go the next year—and the next year brings the same remark.

I am personally promising each and every member of the Fourth District that attends this meeting a well-spent three days in every way. Let us all work for the common good of the society in all that we can do, and we will derive more from it than we will ever contribute, and the best way to start is by attending the annual meeting. There you can know the fellows, see what is being done—not for them alone, but for all—and enable yourself to be worth more to your community in your chosen profession.

It is not necessary for me to dwell upon the importance of attending this meeting, as you are well versed on the subject. Let us all look forward to "Our Meeting" and be there when it starts and remain until it ends. May I add this: I believe there is something in "them thar mountains besides gold."

G. L. Hooper, D.D.S.,
President, Fourth District.

FIFTH DISTRICT

The old Fifth District has lived up to its reputation for good meetings, and plenty of them. In addition to a well-nigh perfect district meeting at Greenville, other group meetings were held in Goldsboro, Hertford, and Greenville. These group meetings were all well attended and successful. From the standpoint of timely discussions, good fellowship, and mutual helpfulness they were perfect. Above everything else, they brought everybody together in a friendly, informal fashion, so that the young men could get to know the older ones and the older ones the young men. We are very proud of both.

The group gathering is the idea of Dr. Paul Jones, of Farmville. Paul, we congratulate you.

Now, the good groundwork of these group meetings must not be lost. Let's keep the bond of friendship and personal interest by seeing one another at the State meeting at Blowing Rock.

A. M. Schultz, D.D.S.,
Editor, Fifth District.

I am thinking of the New Deal, Emergency Relief, the different codes, health insurance, State dentistry, and the various complex problems which confront our profession today.

Within the past two years we have seen our Government, its financial, business, and agricultural interests completely revolutionized. Our ways of thinking in regard to individualism have so completely changed that we can hardly recognize where we stand today.

Can we hope to escape the evolution we see in the present time? It is unreasonable to think that we will not be affected, however, if there are to be changes, and there will be, we must act wisely and in time so that we may not suffer too great a loss.

In England the physicians have found it necessary to form a union in order to deal collectively with the government. We have made a rather sorry mess in our handling of this question, and somehow we must formulate plans whereby we can deal with the governmental agencies with reasonable results.

We have discussed panel and State dentistry, and it is an evident fact that it is not only possible, but, that it is probable that we are confronted in the near future with great changes in our profession. Will they be beneficial, or will they be detrimental? To meet the changing conditions we shall need the best thought of every individual member of our profession, for these problems are before us today, and out of this comes the dental profession of tomorrow.

Dentistry, as we know it today, is not something that just happened. We have reached our present stage of progress and development through the efforts of strong men, and over a long road of travail. We are rapidly approaching the time when only by collective effort can we hold to those rights which we now look on as traditionally our own.

To base our opinions, in many instances, we have no experience to go by, and for this very reason we may find ourselves traveling in paths which lead out into the woods, paths which have no destination. Our guiding organization is the North Carolina Dental Society, our next meeting is at Blowing Rock, June 17.

We boys down East have not been anywhere in a good while, and what we need is a trip. So, I can promise you Up-State fellows we will be with you at Blowing Rock.

PAUL FITZGERALD, D.D.S.,
President, Fifth District.

COMMERCIAL EXHIBITS

We invite you to visit the commercial exhibits, as you will find them both interesting and educational. Please keep in mind the fact that the exhibitors play a large part in making our meeting a success.

EXHIBIT COMMITTEE.

1935 EXHIBITORS

Rothstein Dental Laboratories, 1616 K Street, N. W., Washington, D. C.

Harris Dental Company, Medical Arts Bldg., Norfolk, Virginia.

Raleigh Dental Laboratory, Professional Bldg., Raleigh, N. C.

Powers and Anderson Dental Company, 603 East Main Street, Richmond, Va.

Thompson Dental Company, P. O. Box 1020, Greensboro, N. C.

Woodward Prosthetic Company, N. C. Bank Bldg., Greensboro, N. C.

Fleming Dental Laboratory, Professional Bldg., Raleigh, N. C.

Eberhart-Conway Company, Rhodes Bldg., Atlanta, Ga.

Iodent Chemical Company, 1535 Sixth Street, Detroit, Michigan.

R. Lee Tombs, First National Bank Bldg., Charlotte, N. C.

R. D. Webb Dental Manufacturing Company, P. O. Box 1541, Atlanta, Ga.

Pycopé, Incorporated, 531 Kentucky Avenue, Joplin, Mo.

George Popper, 31 Union Square, New York, N. Y.

Health Products Corporation, 321 Walton Bldg., Atlanta, Ga.

Ray-Lyon Co., P. O. Box 1368, Atlanta, Ga.

Your attention is called to the American Dental Asscciation Exhibit under the direction of Dr. W. M. Matheson.